

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17671

CERTIFICATE OF DEATH

17682

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Maryland b. COUNTY Montg.										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md.			c. LENGTH OF STAY IN lb Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3905 Washington St.				d. STREET ADDRESS 3905 Washington St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Katharine Middle J. Last Adams				4. DATE OF DEATH Month December Day 14 Year 1968										
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/16/1891								
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR Months 1 Days 2 Hours 15 Min.		11. IF UNDER 24 HRS. Hours 15 Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ulric Hutton				14. MOTHER'S MAIDEN NAME ? Janney										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-0082		17. INFORMANT 3905 Washington St. Page Dinnel- Kensington, Maryland										
MEDICAL CERTIFICATION 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crate Myocardial Infarct 4120 DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Hypertensive Cardiovascular Disease (c) Yes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 4201 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 1 hr 2 hr Yes							
							20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
							20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
							21. I certify that (I) (this hospital), attended the deceased from 12/16/68 to 12/17/68 , that (I) (we) last saw the deceased alive on 12/16/68 , and that death occurred at 11 A M, from causes on and on the date stated above.							
22a. SIGNATURE C.H. Ligon MD				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/17/68								
22c. PHYSICIAN'S NAME (Type) C.H. Ligon MD				22d. ADDRESS SUNNY SPRING MD 20860										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/16/1968		23c. NAME OF CEMETERY OR CREMATORY Woodside Cemetery		23d. LOCATION (City or Town) (County) (State) Brinklow Md.								
24. FUNERAL DIRECTOR Tyson Wheeler 1331 Rockville Pike Rockville, Maryland				25a. REC'D BY REGISTRAR DEC 17 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17683

1. DECEASED-NAME (Type or Print) First Middle Last GILMORE AUGUSTA ADDISON			2a. DATE KNOWN OF DEATH Month Day Year 12/7/ 1968		2b. HOUR 5 p.M
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH July 7, 1919	6. AGE (In years last birthday) 49 YRS.	IF UNDER 1 YEAR MONTHS DAYS 12 7	IF UNDER 24 HRS. HOURS MIN. 15
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Plumbing	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME First Middle Last NOAH NMN ADDISON		15. MOTHER'S MAIDEN NAME First Middle Last ALCINDA LOUISA PROCTOR		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16b. SOCIAL SECURITY NO.		17. INFORMANT MGH Records		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound, left chest, 965X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) with exsanguination DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 981X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 500 P.M. 12-7 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased shot in left chest by son who used shotgun	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State 2815 Norbeck Rd. Silver Spring Montg Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Yeap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED DEC. 7, 1968	
EXAMINER'S NAME (Type) BELDEN R. YEAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-11-1968		23c. NAME OF CEMETERY OR CREMATORY ASH MEMORIAL CEM.	
24. FUNERAL DIRECTOR Robert L Snowden		ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DEC 13 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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1. DECEASED NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Clara V. Albright					12 26 1968					11:55 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
F	W.	2-4-03		65 YRS.	MONTHS DAYS		HOURS MIN		12 26 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
PENNA.		U. S. A.				Montgomery				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		641 Sligo Avenue				Secretary		Business		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Montgomery		S. S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		641 Sligo Ave. #201		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
William Gilbert			Kurr		Jenny			--	Leonard	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no		--		176-24-0710		Leland Albright 641 Sligo Avenue, Sil. Spr. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency										
4129 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Belden R. Reap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Belden R. Reap M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county)		Dec. 26, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12-30-1968		Morningside Cemetery		DuBois Dearfield & Pa.				
24. FUNERAL DIRECTOR		J. W. Lee		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Warner E. Pumphrey, Inc.		8434 Georgia Avenue		Sil. Spr. Md.		DATE JAN 3 1969		J. Charles Judge		

1585

2302 L. HALL

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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17672

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17685

1. DECEASED-NAME (Type or Print) Arthur A. F.			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 2 Year 1968			2b. HOUR 730 M.										
3. SEX Male		4. RACE W		5. DATE OF BIRTH July 25, 1885		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 12 Day 2 Year 1968		2d. HOUR 730 M.							
7a. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.							
10. CITY OR TOWN OF DEATH Beltsville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S.N. Retired				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Montgom.				13c. CITY OR TOWN Sil. Spr.				13d. INSIDE CITY (LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 8005 Barron St.			
14. FATHER'S NAME Carl F.				First Middle Last				15. MOTHER'S MAIDEN NAME Unknown - Anderson				First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				(If yes give war or dates of service) Navy				16b. SOCIAL SECURITY NO.				17. INFORMANT Capt. Carlton F. Agui				ADDRESS 8005 Barron St. Beltsville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF, (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 4201												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Belden R. Ream				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED DEC 2, 1968							
EXAMINER'S NAME (Type) BELDEN R. REAM, M.D.				ADDRESS (City or town or county)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (City or town or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec 6-1968				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY Beltsville National				23d. LOCATION (City or Town) (County) (State) Beltsville Va.							
24. FUNERAL DIRECTOR Arthur Walters				ADDRESS 254 Barron St				25. DATE DEC 6 1968				26. REGISTRAR'S SIGNATURE Charles Judge							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF VITAL STATISTICS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First HENRY Middle T. Last ALTHEIDE		2. DATE OF DEATH Month 12 Day 26 Year 1968		2b. HOUR 12:30 M	
3. SEX male		4. RACE white		5. DATE OF BIRTH 10/10/1905	
6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery County		Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Engineer	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	
13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 614 Sligo Ave. Apt. 501	
14. FATHER'S NAME First Henry W. Middle Altheide Last Bertha Schaum		15. MOTHER'S MAIDEN NAME First Bertha Middle Schaum Last Schaum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 577-30-2194		17. INFORMANT Mrs. Anna L. Altheide (Wife) Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 342 x IMMEDIATE CAUSE (a) Parkinsonism DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 350 x		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus, Cerebrovascular					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/10 , 19 68 , to 12/26 , 19 68 , that (I) (we) last saw the deceased alive on 12/26 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE John J. Curry MD		22c. DATE SIGNED 12/26/68		22d. PHYSICIAN'S NAME (Type) John J. Curry MD	
22e. ADDRESS 980 Georgia Ave		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. REGISTRAR'S SIGNATURE Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-28-68		23c. NAME OF CEMETERY OR CREMATORY Ft. Linclon Cemetery	
23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland.		23e. REC'D BY REGISTRAR DATE DEC 30 1968		23f. REGISTRAR'S SIGNATURE Charles Judge	

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OFFICE OF THE

SECRETARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

MONTGOMERY									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) SOPHIA S ALVAREZ			2a. DATE OF DEATH Month 8 Day 19 Year 1968			2b. HOUR 8:50 P.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MAY 5, 1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) XXXXX Ill.		7b. CITIZEN OF WHAT COUNTRY? U.S. of AMERICA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		Md	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3705 WOODBRIDGE AVE.	
14. FATHER'S NAME First Leonard Middle Strzelecki Last Strzelecki			15. MOTHER'S MAIDEN NAME First Rakoseda Middle Koseck Last Koseck			Address 3705 Woodbridge Ave. Silver Spring, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 270-03-3073		17. INFORMANT Mrs. Patricia A. Haganley				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1965 to Dec. 1968 , that (I) (we) last saw the deceased alive on Dec. 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B. L. A. H. E. G.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Dec 8, 1968			
22d. PHYSICIAN'S NAME (Type) B. L. A. H. E. G.				22e. ADDRESS 9801 Daisy Ave. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Dec. 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Calumet City, Illinois			
23e. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				23f. ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE DEC 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

178871

MINISTRY OF DEFENSE

Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text, possibly a signature or name, appearing upside down.

178871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/68

17677										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17688																								
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																								
HELEN F. Amiss										Dec 25 1968										2 AM																								
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					7. YRS.					8. MONTHS					9. DAYS					10. HOURS					11. MIN				
FEMALE					WHITE					12-7-89					79																													
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH										Md																			
Va.					45.										Montgomery																													
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY																													
Bethesda					SUBURBAN					Housewife																																		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER																								
Md.					Montgomery					Bethesda										4860 Chevy Chase Blvd.																								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address																			
John					Selia					No										Helen C. Badger																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					PART 1. DEATH WAS CAUSED BY:					IMMEDIATE CAUSE (a)					DUE TO, OR AS A CONSEQUENCE OF					2 yrs.																								
4129										cardiac arrest																																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b)					DUE TO, OR AS A CONSEQUENCE OF					5 yrs.																													
										congestive failure																																		
										arteriosclerotic disease																																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				4200																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																																		
22a. I certify that (I) (this hospital) attended the deceased from Nov 1968, to Dec 25, 1968, that (I) (we) last saw the deceased alive on 12/24/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																												
22b. SIGNATURE					MARVIN WADLER					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED					12/25/68																								
22d. PHYSICIAN'S NAME (Type)					MARVIN WADLER					22e. ADDRESS										8218 Wisconsin Ave. Bethesda, Md.																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																													
Burial					12-28-68					Forest Oak Cemetery					Gaithersburg, Maryland																													
24. FUNERAL DIRECTOR					ROBERT A. PUMPHREY, Bethesda, Maryland										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE																								
															JAN 2 1969					Charles Judge																								

John A. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)
45M - 1/69

17678		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17689	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last John H. Anderson			2a. DATE OF DEATH Month Day Year Dec. 31, 1968			2b. HOUR 7:45 P.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH Aug. 7, 1901		6. AGE (In years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Vice-president		12b. KIND OF BUSINESS OR INDUSTRY Sales	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont. Co.		13c. CITY OR TOWN Cherry Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3604 Dunlop St.		14. FATHER'S NAME First Middle Last James Theodore Anderson		15. MOTHER'S MAIDEN NAME First Middle Last Hella Liggett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 577-05-1566		17. INFORMANT Ethel Anderson		Address 5130 Wisc Ave NW Wash. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery M. disease 3 yrs DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1965, 19, to 12/31, 1968; that (I) (we) last saw the deceased alive on 12/31/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernard J. Walsh				22c. DATE SIGNED 1/1/69		22d. PHYSICIAN'S NAME (Type) BERNARD J. WALSH	
22e. ADDRESS 1800 EYE ST NW WASH. DC							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Jan 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland Md.	
24. FUNERAL DIRECTOR Jos. Gawler Sons 5130 Wisc Ave NW Wash. D.C.				25a. REC'D BY REGISTRAR JAN 8 1969		25b. REGISTRAR'S SIGNATURE John A. Jones	

[Faint, illegible handwriting covering the main body of the page, likely bleed-through from the reverse side.]

17679

CERTIFICATE OF DEATH

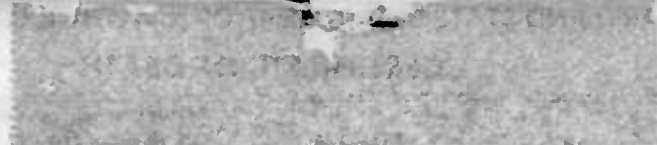
17690
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9206 NORTH AVENUE</u>				d. STREET ADDRESS <u>9206 WORTH AVE</u>			
3. NAME OF DECEASED (Type or print) <u>OLIVE</u> First <u>FRANCES</u> Middle <u>ANKERS</u> Last				4. DATE OF DEATH Month <u>DEC</u> Day <u>3</u> Year <u>1968</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1 APR 1890</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>AMBROSE BLADEN</u>				14. MOTHER'S MAIDEN NAME <u>MARIA GANT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>DAUGHTER</u> Address <u>9206 WORTH AVE</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>4339</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIO SCLEROSIS</u> (c) <u>ARTERIO SCLEROSIS GENERALIZED</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>27 NOV</u> , 19 <u>68</u> , to <u>3 DEC</u> , 19 <u>68</u> , that I last saw the deceased alive on <u>2 DEC</u> , 19 <u>68</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas P. Fogarty</u>				ADDRESS (Street, city or town, state) <u>820 UNIVERSITY BLVD E.</u> DATE SIGNED <u>3 DEC 68</u>			
PHYSICIAN'S NAME (Type) <u>Thomas P. Fogarty</u>				SILVER SPRING, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL-BURIAL</u>		22b. DATE THEREOF <u>12/3/68</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut GROVE</u>		22d. LOCATION (City, town, or county) (State) <u>HERNDON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Berkeley Green, Herndon, Va.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 13 1968</u>		24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02351



THE NEW YORK

LIBRARY

02351

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

17680										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17691																																							
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year																																																	
Alice L. ASHWELL										22 December 1968										8:10A M																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.									
Female										Cauc										1 Sep 1921										47 YRS.										MONTHS DAYS HOURS MIN.																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
Wisconsin										USA																				Montgomery																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY ***																													
Bethesda										Naval Hospital										Housewife																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																			
Bethesda, Maryland										Montgomery										Bethesda										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										929 Bardon Road																			
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																													
Paul L. ISBERNER																				Myrtle McNICOL																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										(If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																			
NO										***										322-24-9391										James T. ASHWELL, 929 Bardon Rd., Bethesda, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
485X										IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia, Left Upper Lobe</u>																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																							
										(c)										DUE TO, OR AS A CONSEQUENCE OF																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										491X																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																																							
										HOUR A.M. Month Day Year P.M. 19																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION										Street or R.F.D. No. City or Town County State																													
22a. I certify that (A) (this hospital) attended the deceased from December 14, 1968, to December 22, 1968, that (we) last saw the deceased alive on December 22, 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (B) (we) did (not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
										12/23/68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
S. F. DOVI, LCDR MC USN										Naval Hospital, Bethesda, Maryland																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										12/24/68										Arlington National Cemetery										Arlington Va.																													
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
Robert A. Pumphrey Funeral Home										JAN 2 1969										f Charles Judge																																							
7557 Wisconsin Ave., Bethesda, Md.																																																											

17081

22 December 1968

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VR 151-14
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <i>Claude B. Ashwell</i>						2a. DATE OF DEATH Month Day Year <i>12-26-68</i>			2b. HOUR <i>5:20 A</i>		
3. SEX <i>MALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>1893 12-23-1894</i>		6. AGE (In years last birthday) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY Co - Md.</i>					
10. CITY OR TOWN OF DEATH <i>Silver Springs Md</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bella Vista Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Shoemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>store</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>PRINCE GEORGES</i>			13c. CITY OR TOWN <i>Takoma Pk</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>7908 Kennewick Ave.</i>	
14. FATHER'S NAME <i>Daniel</i>			First Middle Last <i>-- Ashwell</i>			15. MOTHER'S MAIDEN NAME <i>Dora M. Witt</i>			First Middle Last <i>--</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>--</i>			17. INFORMANT Address <i>Jak. Park, Md.</i> <i>Sicily Ashwell 7908 Kennewick Avenue</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>57 yrs</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>4200 Diabetes Mellitus</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>9/4</i> , 19 <i>68</i> , to <i>12/26</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/25</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Harold Heiges M.D.</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/26/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>HAROLD HEIGES</i>						22e. ADDRESS <i>5415 Conn. Ave NW Wash DC</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-30-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland Pr. Geor. Md.</i>					
24. FUNERAL DIRECTOR <i>J. W. Warner</i> <i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i>						ADDRESS <i>Sil. Spr, Md.</i>		25a. RECEIVED BY REGISTRAR DATE <i>JAN 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

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220

2. 4. 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17692		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17693			
1. DECEASED-NAME (Type or print) First Middle Last Ruth P Atwood						2a. DATE OF DEATH Month Day Year Dec. 11 1968		2b. HOUR 7:30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-14-1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Kensington			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 11025 Madison Street			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk - V.A.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11025 Madison St.	
14. FATHER'S NAME First Middle Last William O. Parsley			15. MOTHER'S MAIDEN NAME First Middle Last Christina -- Mulligan			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			
16b. SOCIAL SECURITY NO. 214-03-8069			17. INFORMANT Address John Atwood 11025 Madison Street, Kensington Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiac vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs 15 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from July, 1952, to Dec 11, 1968, that (I) (we) last saw the deceased alive on 12/9 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A.D. Bonifant			DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/11/68		
22d. PHYSICIAN'S NAME (Type) A.D. BONIFANT			22e. ADDRESS Sandy Springs, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-14-1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Montg., Md.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Avenue			25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

11883

STATE OF TEXAS
DEPARTMENT OF HEALTH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		35		10-15-1918		Dallas, Texas	
Occupation		Cause of Death		Manner of Death		Physician		Hospital	
Teacher		Typhoid Fever		Natural		Dr. J. H. Smith		St. Paul's Hospital	
Residence		Birthplace		Date of Birth		Date of Admission		Date of Discharge	
1234 Elm St., Dallas, Texas		Dallas, Texas		10-1-1883		10-10-1918		10-15-1918	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased	
J. H. Smith		A. B. Jones		C. D. Brown		E. F. Green		John Doe	
Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature	
10-15-1918		10-15-1918		10-15-1918		10-15-1918		10-15-1918	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First <i>Robert</i>			Middle <i>H</i>			Last <i>Bailey</i>			2a. DATE OF DEATH Month <i>Dec</i> Day <i>14</i> Year <i>68</i>			2b. HOUR <i>6:30</i> M.		
3. SEX <i>Male</i>			4. RACE <i>Caucasian</i>			5. DATE OF BIRTH <i>1 Oct. 1909</i>			6. AGE (In years lost birthday) <i>59</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Tenn.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.								
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rock Cross Hospital</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Carpenter</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Union</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>				13b. COUNTY <i>Montgomery</i>				13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>6610 Alleghany Ave</i>					
14. FATHER'S NAME First <i>J</i> Middle <i>D</i> Last <i>Bailey</i>			15. MOTHER'S MAIDEN NAME First <i>JANE</i> Middle <i>Magwood</i> Last <i>Magwood</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. <i>414-24-9986</i>			17. INFORMANT <i>Mary Carter</i> Address <i>2 Lincoln Lane GOLFERS MISS.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary of Lungs</i> <i>571.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>5810</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>12/11/68</i> to <i>12/14/68</i> , that (I) (we) last saw the deceased alive on <i>12/14/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>John J. Curry</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>12/15/68</i>								
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>Dec. 19, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Sargentsville Town</i>			23d. LOCATION (City or Town) (County) (State) <i>Sargentsville Town</i>								
24. FUNERAL DIRECTOR <i>Edward Walters</i>			24a. ADDRESS <i>254 Carroll St. Washington D.C.</i>			24b. REC'D BY REGISTRAR DATE <i>DEC 18 1968</i>			24c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

11038

STATE OF OHIO

11038

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Page 1 of 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17684		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17695	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Charles Bang</i>			2a. DATE OF DEATH Month <i>Dec</i> Day <i>10</i> Year <i>1968</i>			2b. HOUR <i>9:30</i> M	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>11/8/01</i>		6. AGE (In years last birthday) <i>67</i> YRS. MONTHS <i>11</i> DAYS <i>21</i>	
7a. BIRTHPLACE (State or foreign country) <i>N. J.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Construction</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Private</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>5807 Wagoner Lane</i>		14. FATHER'S NAME First <i>Harold</i> Middle <i>Bang</i> Last <i>Bang</i>		15. MOTHER'S MAIDEN NAME First <i>Andrea</i> Middle <i>Bear</i> Last <i>Bear</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i>		16b. SOCIAL SECURITY NO. <i>224-16-6000</i>		17. INFORMANT <i>Wife Margaret Bang</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, recent & remote, left ventricle (posterior) & septum</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe coronary arteriosclerosis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , 1968, to <i>12/10/1967</i> , that (I) (we) lost saw the deceased alive on <i>12/10/1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W. T. Joyce</i>		DEGREE <i>W. T. Joyce</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>W. T. Joyce</i>		22e. ADDRESS <i>4477 Battery La</i>		City or Town <i>Mont</i> County <i>Md</i> State <i>Ill.</i>			
23a. BURIAL CREMATION <i>XXXX</i>		23b. DATE <i>12-14-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Greenwood</i>		23d. LOCATION (City or Town) <i>WORTH</i> County <i>Cook</i> State <i>Ill.</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS <i>7557-Wisconsin Ave., Bethesda, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>DEC 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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also eloquently mentioned above

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17685

CERTIFICATE OF DEATH

17696

1. DECEASED-NAME (Type or print) Charles Curtis Barbour, Jr.			2a. DATE OF DEATH Month December Day 29 Year 1968			2b. HOUR 10:40 AM	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 26 January 1928		6. AGE (In years last birthday) 40 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) Street Cleaner		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Roanoke		13c. CITY OR TOWN Roanoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1302 Hanover Ave., N. W.		14. FATHER'S NAME First Middle Last Charles C. Barbour, Sr.		15. MOTHER'S MAIDEN NAME First Middle Last Madeline Woods			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 1953-1955 222-30-7277		17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas, with widespread metastasis 6 Months 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 157x							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that X (this hospital) attended the deceased from 7 Nov. , 19 68 , to 29 Dec. , 19 68 , that (X) (we) last saw the deceased alive on 29 Dec. , 19 68 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (not) view the body after death.							
22b. SIGNATURE Michael B. Mosher				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 29 December 1968	
22d. PHYSICIAN'S NAME (Type) Michael B. Mosher, MD.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12/31/68		23c. NAME OF CEMETERY OR CREMATORY Williams Mem. Cem.		23d. LOCATION (City or Town) (County) (State) Roanoke, Virginia	
24. FUNERAL DIRECTOR Fraziers Funeral Home, Washington, D. C.				25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17686										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17697																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										12 11 68																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
Male										White										7-20-97										71 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
Holland										u.s.a.																				Montgomery																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Takoma Park										Washington San. & Hosp.										Retired Restaurant Opr.										Restaurant																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
Virginia										Fairfax										Alexandria										YES <input type="checkbox"/> NO <input type="checkbox"/>										5420 North Morgan Street																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
Dirk										Bart										Dina										Schuit																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)										16b. SOCIAL SECURITY NO. (If yes give war or dates of service)										17. INFORMANT										Address																													
No										577-56-2283										Wash. San Records																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										Liver Failure										3 mos.																																							
1729																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Melanoma, primary										6 mos.??																																							
DUE TO, OR AS A CONSEQUENCE OF										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
1909																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
Nov 21, 1968										Carcinoma-Melanoma of Liver										YES <input type="checkbox"/> NO <input type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Nov 7, 1968, to Dec 11, 1968, that (I) (we) last saw the deceased alive on Dec 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																													
W. W. Eastman																														12-11-68																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
W. W. Eastman, M.D.										531 University Blvd E. Silver Spring Md																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Buried										12/14/1968										Calvary										Fairfax Co. Va.																													
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
Murphy Fun. Home										DEC 17 1968										J. Charles Judge																																							
ARLINGTON, Va.																																																											

178371

DEC 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15
45M - 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
17687					CERTIFICATE OF DEATH					17698				
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR		
Nellie			E.		Beall		Dec. 27, 1968			9:30 M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS			
female		white		11/16/84			24 YRS.		MONTHS		DAYS			
9a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.		
Maryland			U. S. A.					Montgomery						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda			Suburban			Homemaker			Private					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
Md. Montgomery			Rockville					105-Luckett Street						
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		
James P.			Beall		Annie		Randy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No			578-42-1729			Leonard Beall			Rockville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Vascular Insufficiency										Hours				
3979 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 414X (b) Chronic Rheumatic Endocarditis										Years				
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis										Years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
Diverticulitis of Large Intestine														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Dec 18, 1968, to Dec 27, 1968, that (I) (we) last saw the deceased alive on Dec 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Harris M. Kenner M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/28/68						
22d. PHYSICIAN'S NAME (Type) Harris M. Kenner M.D.						22e. ADDRESS 5411 Cedar Lane Bethesda Mont Md								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			12/30/1968		Rockville Cemetery			Rockville Montg. Md.						
24. FUNERAL DIRECTOR 1331 Tyson Wheeler Funeral Home						ADDRESS Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
						DATE JAN 3 1969		J Charles Judge						

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X

• 1944 •

1931
Rockville Pike
Rockville, Md.
369
1931
Rockville Cemetery
Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
William			Thomas			Month 12 Day 8 Year 68			7:45 P M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		August 27, 1885			83 YRS.		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		U.S.A.					Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring			622 Hobbs Drive			Carpenter			Construction
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Sil. Spr.			622 Hobbs Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George W. Beall			Mary E. Wilson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			214-03-8698		E. Caroline Beall 622 Hobbs Drive, Sil. Spr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> <u>185X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>177X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>64</u> , to <u>Dec 8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Bernard A. Fitzgerald M.D.</u>					22c. DATE SIGNED <u>12-8-68</u>				
22d. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>					22e. ADDRESS <u>217 UNIV. BLVD E, SILVER SPRING, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-11-1968		George Washington Cemetery		Adelphi Pr. Georges, Md.			
24. FUNERAL DIRECTOR <u>J.W. Lee Jr.</u> <u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE		

11089

RECEIVED

11089

Handwritten notes and stamps, including "RECEIVED" and "11089".

H

Handwritten notes and stamps at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
17688					CERTIFICATE OF DEATH					17700				
1. DECEASED-NAME (Type or print) <u>Alva F. Beane</u>					2a. DATE OF DEATH <u>12</u> Month <u>25</u> Day <u>68</u> Year					2b. HOUR <u>1:38</u> P.M.				
3. SEX <u>Male</u>			4. RACE <u>White</u>		5. DATE OF BIRTH <u>4-9-94</u>			6. AGE (In years last birthday) <u>74</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <u>Md.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Montgomery</u> Md.						
10. CITY OR TOWN OF DEATH <u>Bethesda</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Variety Store</u>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Self-Employed</u>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>			13b. COUNTY <u>Mont.</u>		13c. CITY OR TOWN <u>Rockville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>129 S. Adams St.</u>					
14. FATHER'S NAME First Middle Last <u>William E. Beane</u>					15. MOTHER'S MAIDEN NAME First Middle Last <u>Ada Burr's</u>					16. ADDRESS <u>Rockville</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no) or (unknown) <u>No</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>216-32-1337A</u>		17. INFORMANT <u>Bessie B. Beane, 129 S. Adams, Rockville</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myelocytic Leukemia</u> <u>2050</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>2043 Azotemia & Acidosis</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 23, 1968</u> , to <u>Dec 25, 1968</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Dec 25, 1968</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.														
22b. SIGNATURE <u>James W. Egan M.D.</u>			22c. DATE SIGNED <u>12.25.68</u>			22d. PHYSICIAN'S NAME (Type) <u>James W. Egan, M.D.</u>								
22e. ADDRESS <u>5413 Cedar Lane - Bethesda Md</u>														
23a. BURIAL, CREMATION, <u>XXXXXX</u>			23b. DATE <u>12-28-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montgomery, Md.</u>						
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, 7557 Wisconsin Ave.</u>			ADDRESS <u>Bethesda, Md.</u>			25a. REC'D BY REGISTRAR <u>JAN 2 1969</u>			25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>					

1350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6210-WEDGEWOOD RD.</u>		d. STREET ADDRESS <u>6210-WEDGEWOOD RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>L.</u> Last <u>Beckley</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1968</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/1909</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH BECKLEY</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN GALLAGHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>4109</u>	
17. INFORMANT <u>EVELYN BECKLEY</u>		Address <u>2 D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Heart Disease</u> DUE TO (c) <u>Arterio-sclerotic heart disease</u> 5 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 1958, to <u>Dec.</u> , 1968, that (I) (we) last saw the deceased alive on <u>4 December 1968</u> , and that death occurred at <u>3 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis X. Richardson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Francis X. Richardson, M.D.</u>		22d. ADDRESS <u>11412 Veirs Mill Road Wheaton, Maryland 20902</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10/23/68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		23d. LOCATION (City, town or county) (State) <u>SILVER SP. MD.</u>	
24. FUNERAL DIRECTOR <u>HANLON FUNERAL HOME WASH.</u>		25a. REC'D BY REGISTRAR <u>JAN 2 1969</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

an accident, the burial was delayed
father, living only, till he was buried
consequently

There were three children of George and Mary, all of whom were buried in the same grave. The first child, a son, was born on the 10th of January, 1840, and died on the 10th of January, 1840, at the age of 10 years. The second child, a daughter, was born on the 10th of January, 1840, and died on the 10th of January, 1840, at the age of 10 years. The third child, a son, was born on the 10th of January, 1840, and died on the 10th of January, 1840, at the age of 10 years.

17701

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 WEST STREET, BALTIMORE, MARYLAND

Acute infectious inflammation

Consecutive heart disease

Arterio-sclerotic heart disease

1115 North 11th Street

Pharmaceutical, Baltimore, Maryland 20901

1928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 2a Form G4-07 12/12/68 kk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
17691		17702	
1. DECEASED-NAME (Type or print) First Middle Last Charles A Bennett		2a. DATE OF DEATH Month Day Year Dec. 13 1968	
3. SEX M		4. RACE White	
5. DATE OF BIRTH 6/21/90		6. AGE (In years last birthday) 78	
7a. BIRTHPLACE (State or foreign country) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clergman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	
13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 5505 Banner St.			
14. FATHER'S NAME First Middle Last George D Bennett		15. MOTHER'S MAIDEN NAME First Middle Last Alice	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 529 40 69964	
17. INFORMANT (Name and address) Vera P.W. Bennett		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>331X</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21e. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 22, 1968</u> , to <u>Dec 4, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Dec 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Robert H. Coale		22c. DATE SIGNED Dec. 4, 1968	
22d. PHYSICIAN'S NAME (Type) ROBERT N COALE		22e. ADDRESS 4429 Bradley Lane Chevy Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-6-1968	
23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery		23d. LOCATION (City or Town) (County) (State) Cheyenne, Wyoming	
24. FUNERAL DIRECTOR 400. Gumbert Lane 5130 Wisconsin		25. REC'D BY REGISTRAR Charles Judge	
25a. DATE DEC 9 1968		25b. REGISTRAR'S SIGNATURE	

8956

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) Christine Marie Bennett										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 27 Year 1968		2b. HOUR 6:50 PM			
3. SEX Female		4. RACE white		5. DATE OF BIRTH 12-21-68		6. AGE (In years last birthday) 6 YRS.		IF UNDER 1 YEAR MONTHS 6 DAYS 6		IF UNDER 24 HRS. HOURS 6 MIN. 50		2c. DATE PRONOUNCED DEAD Month 12 Day 27 Year 1968		2d. HOUR PM	
7a. BIRTHPLACE (State or foreign country) Virginia				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Montgomery				13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				13e. STREET AND NUMBER 607 Vierling Dr			
14. FATHER'S NAME First First Middle Middle Last Last				15. MOTHER'S MAIDEN NAME First First Middle Middle Last Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic viral pneumonitis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 492X															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED DEC. 27, 1968							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE 1-13-69		23c. NAME OF CEMETERY OR CREMATORY Washington San & Hospital				23d. LOCATION (City or Town) (County) (State) Takoma Park Mont. Md.					
24. FUNERAL DIRECTOR J.D. Ruffcorn								ADDRESS 7600 Carroll Ave., Tk Pk, Md.		25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items 5, 6 Film G 408 12/31/68 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17704									
1. DECEASED-NAME (Type or Print) <u>WILLIAM BRUCE BENSON</u>						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month <u>DEC</u> Day <u>14</u> Year <u>1968</u>		2b. HOUR <u>9:15</u> AM	
3. SEX <u>MALE</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH <u>APRIL 11, 1890</u>	6. AGE (in years last birthday) <u>78</u> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month <u>Dec</u> Day <u>14</u> Year <u>1968</u>	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u> Md.			
10. CITY OR TOWN OF DEATH <u>BETHESDA</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>SUBURBAN</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Montgomery Co. Employee</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Roads</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>ROCKVILLE</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>1208 HIGHWOOD ROAD</u>	
14. FATHER'S NAME First <u>William H.</u> Middle <u>Benson</u> Last _____				15. MOTHER'S MAIDEN NAME First <u>Nettie</u> Middle <u>Grimes</u> Last <u>Grimes</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16b. SOCIAL SECURITY NO. <u>720-577-46-7749</u>		17. INFORMANT <u>Alice Ennis - Arlington, Va.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Nephritis -</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>887X</u>									
(b) <u>Septicemia from Decubitus Ulcers -</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Hip Fracture -</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>9040 Cardio Vascular Disease</u>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <u>NOON P.M. Aug 17 1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fell at Home causing Fracture of Hip.</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No. <u>1208 Highwood Rd. Rockville</u>		City or Town <u>Montgomery</u>		State <u>Md.</u>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John S. Bull</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) _____				M.D. _____		22b. DATE SIGNED <u>Dec. 14, 1968.</u>		ADDRESS (Street, city, town, or county) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/17/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monacacy</u>		23d. LOCATION (City or Town) <u>Beallsville Montg. Md.</u>		(County) _____ (State) _____	
24. FUNERAL DIRECTOR <u>W.C. Keith, Barnesville, Md.</u>				ADDRESS _____		25a. REC'D BY REGISTRAR <u>DEC 18 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

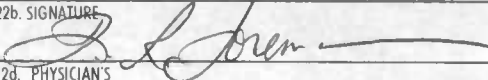

10771

RECEIVED BY THE DEPARTMENT OF THE ARMY

10771

10771

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					
First Middle Last Frances Annette BIRKETT					Month Day Year Dec. 20 68					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH Jan. 24, 1918		6. AGE (In years last birthday) 50 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Florida			13b. COUNTY Monroe		13c. CITY OR TOWN KEYWEST		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2506 Linda Avenue	
14. FATHER'S NAME First Middle Last William Rodney English					15. MOTHER'S MAIDEN NAME First Middle Last Ada Bell KENNERLY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no ***			16b. SOCIAL SECURITY NO. 215-05-1960		17. INFORMANT Address Hospital records, Naval Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCH PNEUMONIA, BILATERAL, BRONCHIAL 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 491X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 15 1968 , to December 20 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 20 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.										
22b. SIGNATURE 					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/22/68			
22d. PHYSICIAN'S NAME (Type) D. R. FOREMAN					22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. REMOVAL OR BURIAL Burial		23b. DATE 12/22/68		23c. NAME OF CEMETERY OR CREMATORY Southern Keys Cemetery		23d. LOCATION (City or town) County State Key West, Monroe Co., Florida				
24. FUNERAL DIRECTOR Robert A. Pumphrey					ADDRESS Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR DEC 26 1968		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17695

AGNES CERTIFICATE OF DEATH

17706

1. DECEASED-NAME (Type or print) <i>Catherine</i>			First Middle Last <i>Bliss</i>			2a. DATE OF DEATH Month Day Year <i>12 9 68</i>			2b. HOUR <i>7:10 P.M.</i>		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>6-27-83</i>			6. AGE (In years last birthday) <i>85</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Senior Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>Pr. Geo.</i>			13c. CITY OR TOWN <i>Hyattsville</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>5801 42nd Ave.</i>			14. FATHER'S NAME First Middle Last <i>Patrick Flannery</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Ellen Kelly</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>Yes, no, or unknown</i>			16b. SOCIAL SECURITY NO. <i>unknown</i>			17. INFORMANT <i>Hosp. Records</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>485X</i> IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>491X</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Two days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Polyt. Parkinson's Disease Arteriosclerosis</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>August</i> , 1967, to <i>December 9</i> , 1968, that (I) (we) lost the deceased on <i>December 9</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stuart Nelson</i>			DEGREE <i>STUART. NELSON</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>12-10-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>STUART. NELSON</i>			22e. ADDRESS <i>Univ. Blvd. E. Silver Spring Md</i>								
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>Dec 12 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington Md</i>		
24. FUNERAL DIRECTOR <i>Stakoma</i>			24a. ADDRESS <i>2940 Pershing St. N.W.</i>			24b. REC'D BY REGISTRAR <i>Charles Judge</i>			24c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
DATE <i>DEC 12 1968</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)			First HARRY			Middle BLUM			Last			2a. DATE OF DEATH Month Dec.			Day 11			Year 1968			2b. HOUR 2:15		
3. SEX M			4. RACE White			5. DATE OF BIRTH Sept. 12, 1899			6. AGE (In years last birthday) 69			IF UNDER 1 YEAR MONTHS			IF UNOFR 24 HRS. DAYS			HOURS			MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery														
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auto-Mgr & Musician			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Mont.			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1131 University Blvd W											
14. FATHER'S NAME David			First			Middle Blum			Last			15. MOTHER'S MAIDEN NAME Sophie Piepert			First			Middle			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Anne Blum, Wife, 1131 University Blvd. W			Address S.S., Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery M. dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>12 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County			State								
22a. I certify that (I) (this hospital) attended the deceased from <u>9/9/57</u> 19 <u>57</u> , to <u>12/11/68</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>10/5/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>Bernard J. Walsh MD</u>			DEGREE			ATTENDING PHYS.			<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>12/11/68</u>											
22d. PHYSICIAN'S NAME (Type) BERNARD J. WALSH MD			22e. ADDRESS 1800 Eye Street, N.W.																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/12/68			23c. NAME OF CEMETERY OR CREMATORY Adas Israel Con. Cem			23d. LOCATION (City or Town) Wash., D.C.			(County) (State)											
24. FUNERAL DIRECTOR Bernard Danzansky & Sons			ADDRESS 3501 14th St. N.W. Wash., D.C.			25. RECORD BY REGISTRAR DEC 16 1968			26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>														

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17697

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17708

1. DECEASED-NAME (Type or print) First Middle Last Charles Edward Bond			2a. DATE OF DEATH 12 Month 19 Day 68 Year		2b. HOUR 8:10 PM
3. SEX Male	4. RACE Colored		5. DATE OF BIRTH 1/4/71		6. AGE (In years last birthday) 97 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery		Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer - Retired	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Sprg.	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2720 Norbeck Road			
14. FATHER'S NAME First Middle Last Thomas Bond		15. MOTHER'S MAIDEN NAME First Middle Last Julie Ann Sedgwick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-44-8240		17. INFORMANT Medical Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 491X Arteriosclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 19, 1968</u> to <u>Dec 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard G. Yates M.D.		22c. DATE SIGNED 12/20/68		22d. PHYSICIAN'S NAME (Type) Richard Yates, M.D.	
22e. ADDRESS Old Baltimore Road, Olney, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-23-68		23c. NAME OF CEMETERY OR CREMATORY ASH MEMORIAL CEM	
23d. LOCATION (City or Town) (County) (State) SANDY SPRING Montg Md.					
24. FUNERAL DIRECTOR Robert L. Snowden Rockville Md		25a. REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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WEST VIRGINIA

Charles Edward Bond

Colonel

outgoing

Post Office General

Post Office General

Bond

Medical Records

Medical Records

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17698 CERTIFICATE OF DEATH 17709									
1. DECEASED-NAME (Type or print) First Middle Last DAVID BORACK			2a. DATE OF DEATH Month Day Year 12 3 68			2b. HOUR 3:50 A M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 8/14/23		6. AGE (In years lost birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BAKER		12b. KIND OF BUSINESS OR INDUSTRY HEIDE BAKING			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND 13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9312 Pine Branch			
14. FATHER'S NAME First Middle Last HARRY BORACK			15. MOTHER'S MAIDEN NAME First Middle Last BELLE BOOKBINDER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or unknown) (If yes give war or dates of service) YES U.S. IT ARMY			16b. SOCIAL SECURITY NO. 217-14-2573		17. INFORMANT MRS. ANITA BORACK, 9312 PINEY BRANCH RD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 248 hrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Dec 2, 1968, to Dec 3, 1968, that (I) (we) last saw the deceased alive on Dec 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernie G. Bender MD				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/3/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS HOLY CROSS HOSPITAL, SILVER SPRING					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-4-68		23c. NAME OF CEMETERY OR CREMATORY RUDOMER VEREIN		23d. LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. RECEIVED BY-REGISTRAR DATE DEC 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Mayer. M. Boyles						Dec 21-68		P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Fe.	W.	Nov. 26, 1907	66 YRS.	MONTHS	DAYS	HOURS	MIN.	Dec. 26	Year 1968
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Penna		U.S.A				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			5807 Aberdeen Rd			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.			Montgomery			Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Maxmillian Sollerger			Elizabeth Deibold						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS	
NO			unknown			HUSBAND		SAME AS ITEM 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>953X</u> <u>Suffocation -</u>									5 min -
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Breathing in Plastic Bag</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
979X									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
<input checked="" type="checkbox"/>			Hour A.M. P.M. Dec 21 1968		Tied. Plastic bag on head -				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home		5807 Aberdeen Rd. Bethesda		Montgomery		Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER		22b. DATE SIGNED	
John G. Ball			JOHN G. BALL			M.D.		Dec 26, 1968.	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
								Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-30-68		St. Augustine's Cem.		Pittsburgh, Penna.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY, Bethesda, Maryland						DATE JAN 2 1969		Charles Judge	

15710

RECORDS OF THE DEPARTMENT OF THE INTERIOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17720										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17711									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First William Middle (NMN) Last Brainin										Month December Day 10 Year 1968										2:00 M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. HOURS			MIN.											
Male			White			1 November 1910			58 YRS.																				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Connecticut			USA						Montgomery Md.																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Bethesda					The Clinical Center					Physician																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Maryland					Prince George Seat Pleasant										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					201 N. Addison Road									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Philip Middle Brainin Last					First Fannie Middle Gaberman Last																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT																			
					214-36-4465					The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> <u>2051</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Buttock abscess and suspected sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic myelogenous leukemia, blastic phase</u> <u>2041</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
															1 week														
															2 weeks														
															5 months														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Gastrointestinal bleeding, aortic insufficiency</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that he (this hospital) attended the deceased from <u>26 Nov.</u> , 19 <u>68</u> , to <u>10 Dec</u> , 19 <u>68</u> , that he (we) last saw the deceased alive on <u>10 December</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (not) view the body after death.																													
22b. SIGNATURE <u>Peter Rosen MD</u> DEGREE										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED <u>10 December 1968</u>														
22d. PHYSICIAN'S NAME (Type) <u>Peter J. Rosen, M.D.</u>										22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE <u>12-12-68</u>					23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN FALLS CHURCH VA.</u>					23d. LOCATION (City or Town) (County) (State)														
24. FUNERAL DIRECTOR <u>BERNARD Danzansky & Sons</u> ADDRESS <u>3501-14th Street, N.W. WASHINGTON, D.C. 20010</u>										25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>DEC 16 1968</u>					25b. REGISTRAR'S SIGNATURE														

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
Lillabel S. Brand					12-21				19	684 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Fe	Cauc	1-6-1900		68 YRS	MONTHS DAYS		HOURS MIN.		12-21 Year 1968 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
N.Y.		U.S.A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hosp.				Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER			13e. STREET AND NUMBER	
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			164-16413 Deerlake Rd.	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
Adin S. Dexter					Anna Dittmer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Husband		ADDRESS		
No		059-30-9239		George F. Brand		Same as Item 13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency										
4110 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart & Disease										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201 Essential Hypertension										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
CAUSE OF DEATH		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Belden R. Keap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		BELDEN R. KEAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, Town, or County)		DEC. 21, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		12/24/68		Cedar Hill Crematory		Suitland, Pr. Geo. Md.				
24. FUNERAL DIRECTOR				7557 Wisconsin Ave.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland				DATE		JAN 2 1969		Charles Judge		

1777

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NEW YORK

1777

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1777

CERTIFICATE OF DEATH

17713

1. DECEASED-NAME (Type or print) <i>James</i>		First		Middle		Last <i>Brown</i>		2a. DATE OF DEATH Month <i>Dec</i> Day <i>19</i> Year <i>1968</i>			2b. HOUR <i>1:20 PM</i>				
3. SEX <i>male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>10/2/26</i>			6. AGE (In years last birthday) <i>42</i> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____				
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>									
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Field Road</i>							
14. FATHER'S NAME <i>James</i>		First		Middle		Last <i>Brown</i>		15. MOTHER'S MAIDEN NAME <i>May</i>		First		Middle		Last <i>Gray</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Kate - Louise Green</i>			Address <i>304 N Adams Rd Rockville Md</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage, massive, spontaneous</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ruptured aneurysm of Circle of Willis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>330X</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____											
22a. I certify that (I) (this hospital), attended the deceased from <i>18 Dec</i> , 19 <i>68</i> , to <i>19 Dec</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>19 Dec</i> , 19 <i>68</i> , and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Frederick S Caldwell</i>		DEGREE		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12/20/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>FREDERICK S CALDWELL, MD</i>		22e. ADDRESS <i>ROCKVILLE, MD</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>12-23-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LINCOLN PARK CEM.</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville Montgo Md.</i>								
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>		ADDRESS <i>Rockville Md</i>		25a. REC'D BY REGISTRAR <i>DEC 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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17703

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17714

1. DECEASED-NAME (Type or print) Dorothy Mary Louise			First Middle Last Brownyard			2a. DATE OF DEATH Month Dec. Day 17 Year 1968			2b. HOUR 12 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 10, 1912			6. AGE (In years last birthday) 56 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			Md.			
10. CITY OR TOWN OF DEATH Sil. Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1606 Noyes Drive			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY own home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Sil. Spr.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME First Middle Last Albert J. Wessner, Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Isabella -- Caldwell			13e. STREET AND NUMBER 1606 Noyes Drive							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. Yes			17. INFORMANT Theodore Brownyard			Address Sil. Spr. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 398X IMMEDIATE CAUSE (a) Coronary atherosclerotic disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocardial disease DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic fever												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 46 yrs 46 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 416X None													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12-15-1968 to 12-17-1968 , that (I) (we) last saw the deceased alive on 12-15-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE John S. Rogers, M.D.			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12-17-68				
22d. PHYSICIAN'S NAME (Type) John S. Rogers, M.D.			22e. ADDRESS 1919 Seminary Rd. Silver Spring Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-20-1968			23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.			ADDRESS Sil. Spr., Md.			25a. REC'D BY REGISTRAR DEC 23 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARTLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17704 CERTIFICATE OF DEATH 17715										
1. DECEASED-NAME (Type or print) First Middle Last Jeanne Baldwin Buell			2a. DATE OF DEATH Dec. Month 14 Day 1968 or			2b. HOUR 7:45 M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 11, 1928		6. AGE (In years last birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) France		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Chevy Chase			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 106 Quincy St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Teacher		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 106 Quincy St.	
14. FATHER'S NAME First Middle Last Joseph C. Baldwin			15. MOTHER'S MAIDEN NAME First Middle Last Marthe Guillon-Verne							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 578-42-9115		17. INFORMANT Address William R. Buell - HUSBAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OVARIAN CARCINOMA 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 to 2 mo										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1750										
19a. DATE OF OPERATION 2/12/67		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 12/12, 1968, to 12/14, 1968, that (I) (we) last saw the deceased alive on 12/13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A. J. Brennan M.D.				22c. DATE SIGNED 12/14/68		22d. PHYSICIAN'S NAME (Type) A. J. Brennan				
22e. ADDRESS Chevy Chase, Md.										
23a. BURIAL, CREMATION, or other disposition Cremation		23b. DATE Dec. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland Prince George Md.				
24. FUNERAL DIRECTOR Address Jos. Gawler's Sons 5130 Wisconsin Ave. Washington, D.C.				25a. REC'D BY REGISTRAR DATE DEC 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Mary		Teresa	Bulger	December 23 1968		9:00 P			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		
Female	White		21 April 1920		48 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York	USA				Montgomery Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		The Clinical Center, NIH		Examiner		Clothing			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
New York		17		Little Falls		YES		217 Flint Avenue	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
John		Teresa		Durrn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		Unavailable		The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 2029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lymphoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Sjogren's syndrome</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 8 months 12 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 2021									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that NO (this hospital) attended the deceased from <u>Dec. 17</u> , 19 <u>68</u> , to <u>23 Dec.</u> , 19 <u>68</u> , that it (we) last saw the deceased alive on <u>December 23</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, NO (we) did not view the body after death.									
22b. SIGNATURE <u>Henry B. Kaltreider, M.D.</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 24 December 1968			
22d. PHYSICIAN'S NAME (Type) Henry B. Kaltreider, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Removal		12-25-1968				Little Falls, New York			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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1. DECEASED NAME (Type or print)		First CLIFTON		Middle R.		Last BURDETTE		2a. DATE OF DEATH		Month DEC		Day 20		Year 1968		2b. HOUR 3:30 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3/18/1900				6. AGE (In years last birthday) 68 YRS.		7c. UNDER 1 YEAR MONTHS		7d. UNDER 1 YEAR DAYS		7e. UNDER 24 HRS. HOURS		7f. UNDER 24 HRS. MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input type="checkbox"/>		8. NEVER MARRIED <input checked="" type="checkbox"/>		8. DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY							
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) road construction				12b. KIND OF BUSINESS OR INDUSTRY County							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8547 Emory Grove Rd.									
14. FATHER'S NAME First Richard T.		Middle Burdette		Last Laura		15. MOTHER'S MAIDEN NAME First Thompson		Middle Thompson		Last Thompson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown no		16b. SOCIAL SECURITY NO. 213-40-8034		17. INFORMANT Jusie		Address Burdette											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																	
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Bronchopneumonia (Klebsiella-aerobacter)</u> 3 weeks																	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Infarcts old & recent</u> weeks & years																	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
332x <u>Diabetes mellitus</u>																	
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 4, 1968</u> , to <u>Dec. 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Joseph A. Romeo MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/21/68							
22d. PHYSICIAN'S NAME (Type) Joseph A. Romeo MD		22e. ADDRESS 8218 Wisc. Ave. Bethesda, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/23/1968		23c. NAME OF CEMETERY OR CREMATORY Neelsville Ch. Cem.				23d. LOCATION (City or Town) (County) (State) Neelsville, Montg. Md.									
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		1331 ADDRESS Rockville Pike		REC'D BY REGISTRAR DEC 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge											

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FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17718

1. DECEASED-NAME (Type or Print) First Middle Last <i>Clifford Clave Burnett</i>		2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year <i>Dec. 3 1968</i>		2b. HOUR <i>A M</i>
3. SEX <i>M</i>	4. RACE <i>W.</i>	5. DATE OF BIRTH <i>Jan 27-1933</i>	6. AGE (In years last birthday) <i>35</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
9. COUNTY OF DEATH <i>Montgomery</i>		Md.		
10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>10 E Diamond Ave Gaithersburg</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Mechanic</i>
12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Gaithersburg</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13d. STREET AND NUMBER <i>10-E Diamond Ave.</i>				
14. FATHER'S NAME First Middle Last <i>George Burnett</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Marie Shupe</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Peggy Hepsley</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> Pulmonary edema, Acute <i>9509</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs. ?</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>971.8</i>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year ? HOUR A.M. ? P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Took overdose of some drugs</i>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. City or Town County State <i>10 E. Diamond Ave. Gaithersburg Montg. Md.</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John S. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>Dec-4, 1968</i>
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-6-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive</i>	
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>		23d. LOCATION (City or Town) (County) (State) <i>Towles Va</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 6 1968</i>
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

HEALTH UNIT
STATE

MINNESOTA DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17718

Name of Deceased		Date of Death	
Place of Death		Time of Death	
Cause of Death		Manner of Death	
Disease or Injury		Occupation	
Age		Sex	
Race		Marital Status	
Education		Religion	
Social History		Family History	
Medical History		Mental History	
Physical Examination		Laboratory Findings	
Postmortem Examination		Disposition of Body	
Signature of Examiner		Signature of Coroner	
Date of Certificate		Place of Issuance	

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17798		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				177719					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First JOHNXX John		Middle T.		Last BURNS		2c. DATE OF DEATH Month Dec Day 28 Year 1968		2b. HOUR 12:30 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 3, 1893		6. AGE (In years birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Germantown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital admission) STATE Md.		12a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Montg.		12b. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Printer		12c. KIND OF BUSINESS OR INDUSTRY			
13a. CITY OR TOWN Rockville		13b. COUNTY Montg.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 11303 Creek Shore Pl.					
14. FATHER'S NAME Mr James NMC		First Burns		Middle Mary		Last Barnett					
15a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		15b. SOCIAL SECURITY NO.		15c. INFORMANT Lee Burns					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		16c. INFORMANT Same as item 13c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A arteriosclerotic disease DUE TO, OR AS A CONSEQUENCE OF (c) years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instantaneous	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 advanced arteriosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 27 Jan, 19 67, to 28 Dec, 19 68 , that (I) (we) last saw the deceased alive on Dec 10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John G. Fawcett		22c. DATE SIGNED 12/28/68		22d. PHYSICIAN'S NAME (Type) John G. Fawcett							
22e. ADDRESS Dawsonville, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/31/1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Montg. Md.					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		1331 ADDRESS Rockville Pike		24b. REC'D BY REGISTRAR JAN 3 1969		24c. REGISTRAR'S SIGNATURE Charles Judge					

17719

THE STATE OF TEXAS

John A. Tawcett

John A. Tawcett, State of Texas, County of Rockwall, State of Texas, June 3, 1897

John A. Tawcett, State of Texas, County of Rockwall, State of Texas, June 3, 1897

John A. Tawcett, State of Texas, County of Rockwall, State of Texas, June 3, 1897

John A. Tawcett, State of Texas, County of Rockwall, State of Texas, June 3, 1897

John A. Tawcett, State of Texas, County of Rockwall, State of Texas, June 3, 1897

John A. Tawcett, State of Texas, County of Rockwall, State of Texas, June 3, 1897

John A. Tawcett, State of Texas, County of Rockwall, State of Texas, June 3, 1897

John A. Tawcett, State of Texas, County of Rockwall, State of Texas, June 3, 1897

John A. Tawcett, State of Texas, County of Rockwall, State of Texas, June 3, 1897

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17709

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17720

1. DECEASED-NAME (Type or Print) <u>Stanley</u> First <u>F</u> Middle <u>Burrows</u> Last			2a. DATE KNOWN <input type="checkbox"/> OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <u>Dec 25</u> 19 <u>68</u> Month <u>Dec</u> Day <u>25</u> Year <u>1968</u>			2b. HOUR <u>2</u> P. M.							
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH		6. AGE (in years last birthday) <u>71</u> YRS. <u>Unknown</u>		2c. DATE PRONOUNCED DEAD Month <u>Dec</u> Day <u>27</u> Year <u>1968</u>		2d. HOUR <u>M</u>			
7a. BIRTHPLACE (State or foreign country) <u>Md.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Montgomery</u> Md.				
10. CITY OR TOWN OF DEATH <u>Bethesda.</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>5519 Pollard Rd.</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>				13b. COUNTY <u>Montgomery</u>				13c. CITY OR TOWN <u>Bethesda</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>5519 Pollard Rd.</u>	
14. FATHER'S NAME First <u>Unknown</u> Middle <u>Unknown</u> Last <u>Unknown</u>						15. MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle <u>Unknown</u> Last <u>Unknown</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> (If yes give war or dates of service)						16b. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>LONG D. Chambliss</u> ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage Cerebral.</u> <u>412.4</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cardio Vascular Disease -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arterio Sclerosis.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u> <u>Years.</u> <u>Years.</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>422.1</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year <u>19</u> HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>John G. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>Dec-28, 1968</u>					
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>XXX</u>				23b. DATE <u>1-6-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>				23d. LOCATION (City or Town) (County) (State) <u>Rockville Montgomery Md.</u>			
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>7557-Wisconsin Ave., Bethesda, Md.</u>						25a. REC'D BY REGISTRAR <u>JAN 10 1969</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

14730

MEDICAL EXAMINATION CERTIFICATE OF DEATH

REPORT OF THE MEDICAL EXAMINER TO THE JURY

FOR THE

STATE OF MICHIGAN

DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

John G. Sall

1-6-55

Bathman

JAN 10 1955

7557 Wisconsin Ave., Bethesda, Md.

Rockville Montgomery, Md.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <i>Garland E Burton</i>						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> <i>Dec 18 1968</i>			2b. HOUR- <i>9:12 M</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>4/28/66</i>	6. AGE (In years lost birthday) <i>2</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>Dec</i> Day <i>18</i> Year <i>1968</i>			2d. HOUR <i>9:12 M</i>		
7a. BIRTHPLACE (State or foreign country) <i>Montgomery</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Rockville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Rockville</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <i>Garland</i> Middle <i>Burton</i> Last <i>Burton</i>			15. MOTHER'S MAIDEN NAME First <i>Pauline</i> Middle <i>Shifflett</i> Last <i>Shifflett</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					
16b. SOCIAL SECURITY NO.			17. INFORMANT <i>Pauline Burton</i>			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxia</i> <i>912x</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Breathing in Plastic Bag</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i> <i>5 min.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>9240</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>9 A.M. 12/18 1968</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Child put plastic bag over head</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>			21f. LOCATION Street or R.F.D. No. City or Town County State <i>600 Blanford St Rockville Montgomery Md.</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Dec 18, 1968</i>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <i>Charles Judge</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-21-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Flowery Hill Church</i>			23d. LOCATION (City or Town) (County) (State) <i>Redland mntg Md</i>				
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>				ADDRESS <i>Gaithersburg, Md.</i>				25a. REC'D BY REGISTRAR <i>DEC 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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RECEIVED - EXHIBIT - CIVIL SERVICE

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17721

CERTIFICATE OF DEATH

17722

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>8801 Glenville</u>	
3. NAME OF DECEASED (Type or print) <u>First Jacob Middle Butker Last</u>		4. DATE OF DEATH <u>Month 12 Day 24 Year 1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baker</u>	9. AGE (In years last birthday) <u>97</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian Butker</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Taufenback</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>200075074</u>	
17. INFORMANT <u>Wm. Robbins</u>		Address <u>8801 Glenville Silver Spring Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>428X Hypertensive Pneumonia</u> DUE TO (b) <u>Ch. Org. Myocarditis</u> DUE TO (c) <u>fatigue</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>2 yrs 24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u>4222</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> , 19 <u>68</u> , to <u>12/24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>68</u> , and that death occurred at <u>3:10</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Howard Mouse</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12/24/68</u>
22c. PHYSICIAN'S NAME (Type) <u>Howard Mouse M.D.</u>		22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Dec. 27-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenacres</u>	23d. LOCATION (City or Town) (County) (State) <u>Pittsburgh Penna.</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Carroll St. DC.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 30 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

11332

CERTIFICATE OF DEATH

11332

DEC 20 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corob papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17712 CERTIFICATE OF DEATH 17723											
1. DECEASED-NAME (Type or print) First ELLA Middle C. Last BUTLER				2a. DATE OF DEATH Month 19, Day 68 Year December 1968				2b. HOUR 12:45 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 14, 1905		6. AGE (In years 63 birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11113 Midvale Rd. Kensington Maryland			
14. FATHER'S NAME First Middle Last Garrett Cooley				15. MOTHER'S MAIDEN NAME First Middle Last Effie Mills							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service) -----		16b. SOCIAL SECURITY NO. 578-24-0903		17. INFORMANT Address Wilton L. Butler-husband same item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks. ?											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201 Carcinoma, metastatic											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Nov, 1968, to Dec, 1968, that (I) (we) last saw the deceased alive on Dec 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George Sharpe M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/19/68			
22d. PHYSICIAN'S NAME (Type) George Sharpe M.D.		22e. ADDRESS 10511 Summit Ave. Kensington, Md.									
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial		23b. DATE 12/21/68		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City or Town) (County) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1351 Rock Pike Rockville, Md.		25a. REC'D BY REGISTRAR DATE DEC 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

17723

Female
May 14, 1904
December 10, 68
15:15

Montgomery

U. A.

Montgomery

Edith Clark

Willy Gross Montclair

Silver Spring

Montgomery Washington
1111 Avenue B. Washington

Edith Clark

Garnett Cooley

Wilson L. Butler-head and firm

1908-2-90

No

10711 Avenue Ave. Washington, D.C.

Parkman University

12/21/68

Mont

Lydon Heister - several home 12/21/68

Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
177713 CERTIFICATE OF DEATH 177724									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Flor A Saloma Butler						Month Day Year			620 th M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR	
Female	CAUCASIAN		8-14-1889			77 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Wash. D.C.		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cherry Chase			Siloma Springs Nursing Home			Housewife			own home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Mont.		Kensington			3603 PERRY Ave	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Herbert - Ellsworth			Mary - Clark						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
no			579-22-7824-A		Address Kensington, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Metastatic brain tumor									
1890 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Hypernephroma left kidney									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
180X Arteriosclerotic heart disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
			HOUR A.M. Month Day Year						
			P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1959, 19, to Dec. 2, 1968, that (I) (we) last saw the deceased alive on December 1, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Elaine W. Murphy M.D.					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
									December 2, 1968
22d. PHYSICIAN'S NAME (Type) Elaine W. Murphy, M.D.					22e. ADDRESS 4812 Elliott St. NW				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			12-5-1968		Parklawn Cemetery		Rockville Montgomery Md.		
24. FUNERAL DIRECTOR C. Glen Carter					ADDRESS Sil. Spr. Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Warner E. Pumphrey, Inc. 8434 Georgia Avenue							DEC 3 1968		Charles Judge

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR
Margaret Phee Buzzell						12 9 1968			5 43 M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	
Fe	W.	MAY 29, 1934	34 YRS.					Dec 9 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Illinois		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Gaithersburg			19115 Roman Way						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
Md.			Montgomery Gaithersburg					19115 Roman Way.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
JOHN JAMES PHEE			BETH BATTLES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
			353-28-3788		WARD V. BUZZELL, HUSBAND, SAME AS #13A.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post Partum Hemorrhage</u> 653X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atony of Uterus and laceration of Vaginal Wall</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 675X									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Dec 10, 1968	
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		12-11-1968		Cedar Hill Crematory		Suitland, Prince Georges Co., Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				DATE DEC 19 1968		J Charles Judge			

11775

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

January 1, 1963

REPORT OF THE

COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES

AND

THE ATTORNEY GENERAL

ON THE PROCEEDINGS OF THE

COMMISSIONER

AND THE ATTORNEY GENERAL

IN THE MATTER OF

[Handwritten signature]

15-1-1963

DEPARTMENT OF SOCIAL SERVICES

DEC 13 1968

Joseph J. ...

...

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) OWEN R BYRD		First		Middle		Last		2a. DATE OF DEATH Month Dec Day 4 Year 1968		2b. HOUR 140	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 30, 1892		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS OAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) WASHINGTON		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PRESSMAN			12b. KIND OF BUSINESS OR INDUSTRY GPO		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5605 ALDERBROOK CT.			
14. FATHER'S NAME ARLEY		First		Middle		Last		15. MOTHER'S MAIDEN NAME MARY HARDESTY		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) yes (If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO. 230-50-8376		17. INFORMANT HOPE BYRD - WIFE Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Myocardial infarction, recent and old, left myocardium and septum DUE TO, OR AS A CONSEQUENCE OF (b) Severe coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from May , 19 48 , to Dec , 19 48 , that (I) (we) lost saw the deceased alive on 3 Dec 19 48 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eugene P. Libre MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4 Dec 1948	
22d. PHYSICIAN'S NAME (Type) EUGENE P. LIBRE		22e. ADDRESS 10400 Conn. Ave KENSINGTON Md. 20795									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/6/68		23c. NAME OF CEMETERY OR CREMATORY Winchester National		23d. LOCATION (City or Town) Winchester		(County) Virginia		(State)	
24. FUNERAL DIRECTOR Tyson Wheeler		ADDRESS 1331 Rockville Pike Rockville, Maryland				25a. REC'D BY REGISTRAR DATE DEC 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17716

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17727

1. DECEASED-NAME (Type or print) First Middle Last Julia Ann Callahan			2a. DATE OF DEATH Month Day Year Dec 23 1968		2b. HOUR 10:30 PM
3. SEX F	4. RACE Cauc		5. DATE OF BIRTH 1/8/1883		6. AGE (In years last birthday) 85 YRS.
7a. BIRTHPLACE (State or foreign country) Wash. DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery		Md.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash. DC		13b. CITY OR TOWN Wheaton		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13d. STREET AND NUMBER 321C Street NE					
14. FATHER'S NAME First Middle Last Patrick McGill			15. MOTHER'S MAIDEN NAME First Middle Last Mary Callahan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no or unknown) No		16b. SOCIAL SECURITY NO. 517-07-662		17. INFORMANT John W.-son	
Address 9326 Limestone Pl., Cl. Pk.		Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Anemia; Nephroses 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes and generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 260X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-4, 1968, to 12-23, 1968, that (I) (we) last saw the deceased alive on 12-23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Pedro I. Matias, M.D.		22c. DATE SIGNED 12/23/68		22d. PHYSICIAN'S NAME (Type) PEDRO I. MATIAS, M.D.	
22e. ADDRESS 4712 Montgomery Pl, Beltsville Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-27-1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City or Town) (County) (State) Washington, D.C.					
24. FUNERAL DIRECTOR Lee Fun. Home 300 4th St. NE Wash., D.C.		25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

14733

STATE OF DEATH

DEC 30 1888

Clear to Dr. Kemp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Frank (Franco) -- Calvisi						2a. DATE OF DEATH Month Day Year 12-11-68			2b. HOUR 7:00 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-17-1903		6. AGE (in years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant			12b. KIND OF BUSINESS OR INDUSTRY Retail		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 510 Wolf Dr.			
14. FATHER'S NAME First Middle Last Dominic Calvisi				15. MOTHER'S MAIDEN NAME First Middle Last Rubina (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO --		16b. SOCIAL SECURITY NO. 578-26-9945		17. INFORMANT Address Emilia Calvisi 510 Wolf Drive, Sil. Spr. Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8/1, 1939, to 12/11, 1968, that (I) (we) last saw the deceased alive on 12/11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. LEONARDO						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/11/68			
22d. PHYSICIAN'S NAME (Type) C. LEONARDO						22e. ADDRESS 5801-13th St NW Wash. DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-14-1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION (City or Town) (County) (State) Sil. Spr. Montgomery Md.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.						ADDRESS 424 Georgia Ave.		25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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DEC 16 1988

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
17748										
17729										
1. DECEASED-NAME (Type or print) First Middle Last <i>MARION ELIZABETH CARLISLE</i>			2a. DATE OF DEATH Month Day Year <i>Dec 2 1968</i>			2b. HOUR- MIN. <i>12:30</i>				
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>JAN 6, 1909</i>		6. AGE (In years lost birthday) <i>59</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>14004 Trawick Rd</i>	
14. FATHER'S NAME First Middle Last <i>Nick Nibholson</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Minnie</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Clifton Owen Carlisle husband same item</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4201</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>1963</i> , to <i>12-2</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-2</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>R. B. Jones</i>				DEGREE <i>SW JONES</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12-2-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>DL BUCY / SW JONES</i>				22e. ADDRESS <i>809 Veirs Mill Rd Rockville Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/4/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak</i>		23d. LOCATION (City or Town) (County) (State) <i>Gaithersburg, Maryland</i>				
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i>				ADDRESS <i>1551 Rockville Pike</i>		25a. REC'D BY REGISTRAR <i>DEC 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

1. DECEASED-NAME (Type or Print) TUBES, ANN CARR			First Middle Lost			2a. DATE KNOWN OF DEATH Month Day Year 12-24 1968			2b. HOUR 12:15			
3. SEX F		4. RACE W		5. DATE OF BIRTH 12-30-76		6. AGE (In years last birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) P.I.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) garage worker			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Mont				13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 6500 Riggs Road				14. FATHER'S NAME First Middle Lost James Carr				15. MOTHER'S MAIDEN NAME First Middle Lost Helena Walsh				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 577-07-3336				17. INFORMANT Hosp. Chart				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 12-10 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased fell & hit left hip in nursing home				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. City or Town County State 6500 Riggs Rd. Hyattsville, D.C. Prince George's Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Belden R. Resp, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED DEC. 25, 1968				
EXAMINER'S NAME (Type) Belden R. Resp, M.D.				23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 12-29-68				
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET				23d. LOCATION (City or Town) (County) (State) WASH. D.C.				24. FUNERAL DIRECTOR HANTON FUNERAL HOME - WASH. DC				
25a. REC'D BY REGISTRAR DATE JAN 2 1969				25b. REGISTRAR'S SIGNATURE J Charles Judge								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P 4:45 M	
Alfred			Gabriel		Carter, Sr.	December 10 1968				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Male		White		28 June 1913		55 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Pennsylvania		USA				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			The Clinical Center, NIH			Physician		Medicine		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Pennsylvania					Scranton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		821 North Irving Avenue	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last	
Alfred					Carter	Agnes			McLaughlan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes <input checked="" type="checkbox"/> (No or unknown) <input type="checkbox"/>			1942-1946		The Medical Record Address Not available The Clinical Center, NIH, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>1541</u> DUE TO, OR AS A CONSEQUENCE OF <u>Renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of the rectum & sigmoid colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of the rectum & sigmoid colon</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 weeks</u> <u>1 year</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>154x</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 6</u> , 19 <u>68</u> , to <u>Dec. 10</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 10</u> , 19 <u>68</u> , and that in <u>(our)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>William C. Wood</u> MD DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>11 December 1968</u>		
22d. PHYSICIAN'S NAME (Type) <u>William C. Wood, M. D.</u>					22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Rem-bur		12/12/68		St. Catherine's Cem.		Moscow,		Penna.		
24. FUNERAL DIRECTOR <u>C. M. Ziegler</u>		24b. MURPHY FUNERAL HOME Arlington, Virginia				25a. REC'D BY REGISTRAR DATE <u>DEC 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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David G. Allen

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1. The first group of people who are likely to be affected by the proposed changes are those who are currently employed in the public sector. This group includes civil servants, teachers, nurses, and other public sector employees. They will be affected by the proposed changes to the public sector pension scheme, which will be introduced in 2015. The proposed changes will require them to contribute more to their pension scheme and to receive a lower pension when they retire. This will be a significant change for many of them, as they have previously been able to rely on the public sector pension scheme for their retirement income.

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CERTIFICATE OF DEATH

17732
Reg. Dist. No.

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|---|--------------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
5219 Marlyn Drive | | d. STREET ADDRESS
5219 Marlyn Drive | |
| 3. NAME OF DECEASED
(Type or print) First Olive Middle M. Last CAVE | | 4. DATE OF DEATH Month 12 Day 18 Year 1968 | |
| 5. SEX
Female | 6. COLOR OR RACE
Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-30-1905 |
| 9. AGE (In years last birthday) yrs. 63 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
James L. Mothershead | | 14. MOTHER'S MAIDEN NAME
Myrtle Wright | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
- | | 16. SOCIAL SECURITY NO.
577-07-4534 | |
| 17. INFORMANT
Mr. Robert L. Cave, Husband, same as item #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastases (Osseous/Pulmonary)
DUE TO (b) Carcinoma of The Breast
DUE TO (c) 174x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
17 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 170x | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 7, 1968 , to December 18, 1968 , that I last saw the deceased alive on December 17, 1968 , and that death occurred at 6 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
John F. Gustafson | | DATE SIGNED
915 19th Street, N.W.; Washington, D.C. 12-18-68 | |
| PHYSICIAN'S NAME (Type)
John F. Gustafson | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-20-1968 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Suitland, Prince Georges Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | 24a. REC'D BY REGISTRAR
DEC 23 1968 | |
| | | 24b. REGISTRAR'S SIGNATURE
William J. Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

17732



17732

17732

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17732

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17732

17732

17732

Metastases (Osteous/Pulmonary)
Carcinoma of the Breast

17732

June 7 1908

December 17 08

1912 19th Street, N.W., Washington, D.C.

John F. Johnston

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 17722 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17733 | | | |
| 1. DECEASED-NAME (Type or print) Antonio R. Chagas | | | | | | 2a. DATE OF DEATH December 21 1968 | | 2b. HOUR 9:45 A M | |
| 3. SEX Male | | 4. RACE WHITE | | 5. DATE OF BIRTH 6/25/84 | | 6. AGE (In years last birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Brazil | | 7b. CITIZEN OF WHAT COUNTRY? Brazil | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Physician | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1727 Evelyn Dr | |
| 14. FATHER'S NAME First Carlos Middle E Last Silva | | 15. MOTHER'S MAIDEN NAME First Lidia Middle Barbosa Last Barbosa | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Son - Jose P Chagas Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure
470X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Influenza
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hrs.
2.4 h | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
481X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/20/68 19, to 12/21/68 19, that (I) (we) last saw the deceased alive on 12/21/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ronald W. Barr | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type) RONALD W. BARR | | 22e. ADDRESS 10401 OLD GEORGETOWN RD BETHESDA, MD | | | | | | | |
| 23a. BURIAL CREMATION, Burial | | 23b. DATE 12/24/1968 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) Brazil | | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home | | 1331 Rockville Pike Rockville, Md. | | 25a. REC'D BY REGISTRY DEC 23 1968 | | 25b. REGISTRY SIGNATURE James Judge | | | |

14783

December 21 1968 Chicago Antonio

Male

Nonsexually

Operation None. Hydration

Operation

None

Handwritten notes: "Handwritten" and "Operation"

Handwritten numbers: "3/11" and "2/11"

Bottom section containing various handwritten notes, dates (e.g., 12/10/68, 12/11/68), and names (e.g., "Removal to Bank").

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
45M - 1/69

| <div style="display: flex; justify-content: space-between;"> <div> 17723
 <div style="display: flex; justify-content: space-between;"> <div>1</div> <div>2</div> </div> </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> <div> 17734 </div> </div> | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|-----------------------------------|--------------------------------|--|
| 1. DECEASED-NAME
(Type or print) <i>Carl</i> First <i>Christensen</i> Last | | | | 2a. DATE OF DEATH
Month <i>See</i> Day <i>8</i> Year <i>68</i> | | | | 2b. HOUR
<i>PM</i> | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>6/2/81</i> | | 6. AGE (In years last birthday)
<i>87</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Denmark</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Retired-Carpenter</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md</i> | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Bethesda</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>4621 Maple Ave</i> | | | |
| 14. FATHER'S NAME First <i>Unknown</i> Middle Last | | | | 15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
<i>223-26-8542</i> | | 17. INFORMANT
<i>Daughter Mrs John Scope</i> Address <i>Same as above</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Hemorrhagic Gastritis</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <i>Carcinoma Prostate</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <i>Metastatic Ca</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 177X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-8-1968</i> , to <i>12-8-1968</i> , that (H) (we) lost saw the deceased alive on <i>12-8-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Delwitt E. DeLanter</i> | | | | DEGREE
<i>MD</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12-8-68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Delwitt E. Delanter MD</i> | | | | 22e. ADDRESS
<i>3848 Porter St NW Wash DC</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>12-10-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Washington Mem. Park</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Richmond, Virginia</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
<i>DEC 16 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J Charles Judge</i> | | | |

11134

RECEIVED OF DEATH

11134

RECEIVED OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15
45M - 1-68

| 17724 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17735 | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|----------------------------|--|--|--|--|------|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | First | | | | | Middle | | | | | Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| ELLIS | | | | | A. | | | | | CLAGETT | | | | | Dec | | | | | 19 | | | | | 1968 | | | | | 3:30 PM | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR | | | | | IF UNDER 24 HRS | | | | | | | | | | | | | | |
| MALE | | | | | WHITE | | | | | 11/24/06 | | | | | 62 | | | | | MONTHS | | | | | DAYS | | | | | HOURS | | | | | MIN | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | USA | | | | | | | | | | Montgomery | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | |
| BETHESDA | | | | | SUBURBAN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | 13b. CITY OR TOWN | | | | | 13c. INSIDE CITY LIMITS? | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | |
| STATE | | | | | Montgomery | | | | | Silver Spring | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 21 RANDOLPH ROAD | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | First | | | | | Middle | | | | | Last | | | | | 15. MOTHER'S/MAIDEN NAME | | | | | First | | | | | Middle | | | | | Last | | | | |
| Charles | | | | | Clagett | | | | | Ellis | | | | | Cora | | | | | Allison | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address same as above | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | 21610-2341 | | | | | Daughter in law - Mrs Edna Clagett | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | to brain, adrenals, spleen and lymph nodes | | | | | | | | | | 1 1/2 years | | | | | | | | | | | | | | | | | | | |
| 1621 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1621 | | | | | | | | | | Pneumonia of acute onset (24 hours). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | YES | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION - Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 Dec, 1968, to 19 Dec, 1968, that (I) (we) last saw the deceased alive on 19 Dec, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | OEGREE | | | | | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | |
| Frederick S Caldwell | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 12/20/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FREDERICK S CALDWELL | | | | | | | | | | ROCKVILLE MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | | | 12-23-68 | | | | | Wash. Natl Cemetery | | | | | Suitland Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| W.W. Chambers Co | | | | | | | | | | Silver Spring Md. | | | | | | | | | | DEC 31 1968 | | | | | | | | | | J Charles Judge | | | | | | | | | |

17732

RECEIVED OF CASH

ON HAND OF VENDOR FOR THE FOLLOWING ACCOUNT

TO THE ORDER OF THE
TREASURER OF THE
UNITED STATES OF AMERICA

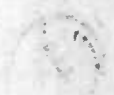
DEC 11 1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--------------------------|--|---|---|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| Item#13a,b,c,e, Film#107 12/11/68 | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| First Middle Last | | | Month Day Year | | | 9:40 AM | | | |
| Elmer Edwin Clayton | | | 12 3 1968 | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| male | | White | | 7-4-91 | | 77 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Vermont | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park Md. | | Washington San. & Hospital | | Book binder | | Printing House | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Montgomery | | Takoma Park | | | | 7706 Garland Avenue | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Edwin Clayton | | | Laurentine Atwood | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| Yes, na, or unknown | | | ? | | Pts chart | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Intracerebral Hemorrhage, massive | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Arteriosclerotic Cardiovascular-Cerebral Dis. | | | | | | | | | |
| 2915 | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1968, to Dec 3, 1968, that (I) (we) last saw the deceased alive on Dec 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE James H. [Signature] | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| | | | | | | | 12-3-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| | | | | | 7717 Carroll Ave Takoma Park Md. | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Dec 5-1968 | | | | Rock Creek | | Washington D.C. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| [Signature] | | | | | DEC 6 1968 | | Charles Judge | | |

17736



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 17726 | | | | | | | | | |
| 17737 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Edgar Frick Clemens | | | | | 2a. DATE OF DEATH
Dec. 18 th Day Year
1968 | | | 2b. HOUR P
8:40 M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
6/14/05 | | 6. AGE (In years
lost birthday)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Penn. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Montgomery General Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
PBX installer | | 12b. KIND OF BUSINESS OR
INDUSTRY
Telephone | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1115 Lewis avenue | |
| 14. FATHER'S NAME First Middle Last
John S. Clemens | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lillian Irene Yeager | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes, give year or dates of service)
yes WW II | | 16b. SOCIAL SECURITY NO.
212-10-0492 | | 17. INFORMANT Address
Records
Montgomery General Hospital, Olney, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cirrhosis of liver - active</u>
5710 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic alcoholism</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 wks.
yes. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
5811 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-6-1968</u> to <u>12-18-1968</u> , that (I) (we) lost saw the deceased alive on <u>12-18-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Frederick Moomau, M.D. | | 22c. DATE SIGNED
Dec. 18, 1968 | | 22d. PHYSICIAN'S NAME (Type)
Frederick Moomau, M.D. | | | | | |
| 22e. ADDRESS
Sandy Spring, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12/21/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rockville Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Md. | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler | | ADDRESS
Funeral Home-1331 Rockville Pike
Rockville, Md. | | 25a. REC'D BY REGISTRAR
DATE
DEC 23 1968 | | 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17722

17738

| | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Mary | | | First Middle Last
E. CLOWER | | | 2a. DATE OF DEATH
Dec. Month 3 Day 68 Year | | | 2b. HOUR
235PM | | | |
| 3. SEX
Female | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
Feb. 24, 1926 | | | 6. AGE (In years last birthday)
42 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country)
Mississippi | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Pr. George | | | 13c. CITY OR TOWN
Bowie | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
R First Q Middle Turner Last | | | 15. MOTHER'S MAIDEN NAME
Lou First Butler Middle Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO (Yes, no or unknown) | | | 16b. SOCIAL SECURITY NO.
428 34 9984 | | | |
| 17. INFORMANT
LCDR W. E. CLOWER | | | Address
12915 Bently Lane, Bowie | | | City or Town
Bowie | | | State
Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of breasts with metastases.
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (s) (this hospital) attended the deceased from Nov. 8 , 19 68 , to Dec. 3 , 19 68 , that (s) (we) last saw the deceased alive on Dec. 3 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Thomas M. Schenk, M.D. | | | DEGREE
M.D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
Dec. 4, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Thomas M. Schenk, M.D. | | | 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | | 23b. DATE
12/4/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
East Fork Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Smithdale Mississ- | | | |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey | | | | | | ADDRESS
Funeral Home, 7557 Wisconsin Ave. Bethesda Md | | | 25a. REC'D BY REGISTRAR
DEC 9 1968 | | 25b. REGISTRAR'S SIGNATURE
ippi | |

265

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|---|---|--|--|---|---|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Christian Hessler COCHRAN | | | 2a. DATE OF DEATH
Dec. Month 15 Day Year 68 | | | 2b. HOUR
430P M | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Apr. 1, 1917 | | 6. AGE (In years last birthday)
51 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U. S. Navy - Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5212 Saratoga Avenue |
| 14. FATHER'S NAME First Middle Last
Richard Benjamin Cochran | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Nona Hessler | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes | | | 16b. SOCIAL SECURITY NO.
217-36-9568 | | 17. INFORMANT Ave., Chevy Chase, Md. (Wife)
Mrs. Mary Townsend Cochran, 5212 Saratoga | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma of Colon with wide spread metastasis
1538
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1538 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from Dec. 10 , 19 68 , to Dec. 15 , 19 68 , that (x) (we) last saw the deceased alive on Dec. 15 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
F. D. Keenan, Jr. MD DEGREE | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
16 December 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
F. D. Keenan, Jr., LCDR MC USN | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-18-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery Arlington | | 23d. LOCATION (City or Town) (County) (State)
Va. | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler Sons ADDRESS
5130 Wisconsin Ave., N.W., Washington, D.C. | | | | | 25a. REC'D BY REGISTRAR
DEC 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

17730

RECEIVED OF WATER

IN 1908

Dec.

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Apr. 1, 1914

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17739 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17740 | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | |
| ABE (NMI) COHEN | | | | | | | | | | Dec. Month 26 Day 1968 Year | | | | | | | | | | 2:00PM | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR | | | | | IF UNDER 24 HRS | | | | | | | | | | | | | | |
| Male | | | | | Cauc. | | | | | Dec. 6, 1877 | | | | | 91 YRS. | | | | | MONTHS | | | | | DAYS | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| New York | | | | | USA | | | | | | | | | | Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Silver Spring | | | | | | | | | | 9039 Sligo Creek Pkwy | | | | | | | | | | Ret. Merchant | | | | | | | | | | Variety store | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | | | | | | | | | Montgomery | | | | | | | | | | Sil. Spr. | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 9039 Sligo Creek Pkwy. | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Marcus | | | | | | | | | | Cohen | | | | | | | | | | Minnie Bush | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | |
| No | | | | | | | | | | 229-60-7569 | | | | | | | | | | Mrs. William Warsaw | | | | | | | | | | Item #13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial INFARCTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) coronary atherosclerosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 10, 1968, to present, 1968, that (I) (we) last saw the deceased alive on Dec 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | |
| Francis Chucker m | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FRANCIS CHUCKER m | | | | | | | | | | 2500 CALVERT ST NW WASH, DC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | | | | | | | | | 12/29/68 | | | | | | | | | | King David Cem | | | | | | | | | | Falls Church Fairfax Va. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Jos. Gawler's Sons | | | | | | | | | | 5130 Wisc. Ave N.W. Washington, D.C. | | | | | | | | | | JAN 2 1969 | | | | | | | | | | J Charles Judge | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> 17730 CERTIFICATE OF DEATH 17741 </div> | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Leo Otis COLBERT | | | | | | 2a. DATE OF DEATH December 23, 1968 mid night | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH December 31, 1883 | | 6. AGE (In years lost birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Coastal Geodetic Survey | | 12b. KIND OF BUSINESS OR INDUSTRY Government | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE District of Columbia D.C. | | | | 13c. CITY OR TOWN Washington D.C. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 4408 29th Street, N. W. | |
| 14. FATHER'S NAME First Middle Last Patrick --- Colbert | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Margaret Byrnes | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI, WWII, Kor | | | | 16b. SOCIAL SECURITY NO. 577-48-3112 | | 17. INFORMANT Daughter Address Mrs. Jeanne C. Doonan, Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma involving Stomach, Rectum and Prostate.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1992 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that NO (this hospital) attended the deceased from December 16, 1968 , to December 23, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 23, 1968 , and that in NO (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE E. Perlman | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) E. PERLIN, LCDR MC USN | | | | 22e. ADDRESS Naval Hospital, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/27/68 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler & Sons, Funeral Home | | | | 25a. REC'D BY REGISTRAR DEC 30 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |
| 5130 Wisconsin Ave., N. W. Washington, D. C. | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Gerhard | | | First Middle Last
(none) Colm | | | 2a. DATE OF DEATH
Month Day Year
December 25 1968 | | 2b. HOUR P
3:25 M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
30 June 1897 | | 6. AGE (In years lost birthday)
71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Economist | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3507 Hamlet Place | |
| 14. FATHER'S NAME First Middle Last
Emil Colm | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Olga Strassburger | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
579-44-1241 | | 17. INFORMANT The Medical Record Address
The Clinical Center, NIH, Bethesda, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia and genitourinary sepsis
203X
DUE TO, OR AS A CONSEQUENCE OF
(b) Multiple myeloma
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week

6 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
203X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that Dr. David A. Bray attended the deceased from Dec. 20, 1968 , to Dec. 25, 1968 , that (1) (we) last saw the deceased alive on 25 December 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
David A. Bray, M.D. | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
26 December 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
David A. Bray, M. D. | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, ETC.
cremation | | 23b. DATE
12/28/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | | | |
| 24. FUNERAL DIRECTOR
JOS. GAWLER SONS INC. | | 5130 Wisc. Ave. N.W. ADDRESS
Wash. D.C. | | 25a. REC'D BY REGISTRAR
JAN 2 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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[Faint handwritten text at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 1 & 5 Film 408 1/2/69 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17743

| | | | | |
|---|--|---|---|---|
| 1. DECEASED-NAME
(Type or print) First <u>May</u> Middle <u>B</u> Last <u>Colton</u> | | 2a. DATE OF DEATH
Month <u>12</u> Day <u>19</u> Year <u>1968</u> | | 2b. HOUR
<u>11:55</u> PM |
| 3. SEX
<u>F</u> | 4. RACE
<u>W</u> | 5. DATE OF BIRTH
<u>11/6/1918</u> | 6. AGE (In years lost birthday)
<u>49</u> YRS. | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
<u>San Antonio, Texas</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. | |
| 10. CITY OR TOWN OF DEATH
<u>Rockville</u> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Potomac Valley Hospital</u> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Housewife</u> | 12b. KIND OF BUSINESS OR INDUSTRY
<u>At Home</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>MD.</u> | 13b. COUNTY
<u>Montgomery</u> | 13c. CITY OR TOWN
<u>Bethesda</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<u>4503 Chestnut St Beth. Md</u> |
| 14. FATHER'S NAME First <u>Andrew</u> Middle <u>Meyer</u> Last <u>Butler</u> | 15. MOTHER'S MAIDEN NAME First <u>Lillian</u> Middle <u>Pringle</u> Last <u>Pringle</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | 16b. SOCIAL SECURITY NO.
<u>388-16-4207</u> | 17. INFORMANT
<u>Barbara C Hughes</u> Address <u>4503 Chestnut St. Bethesda, Md</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PNEUMONIA, RIGHT LUNG</u>
<u>174X</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CARCINOMA, DORSAL SPINE, METASTATIC (BREAST)</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>CARCINOMA, R BREAST, WITH RADICAL MASTECTOMY</u>
<u>1964</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 DAYS</u>
<u>3 Mo.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>170X PARAPLEGIA AND CYSTITIS, URINARY</u> | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1964</u> to <u>DEC 19, 1968</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>DEC 19, 1968</u> , and that in (my) (<u>own</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>was</u>) (did) (<u>did not</u>) view the body after death. | | | | |
| 22b. SIGNATURE
<u>Leo M. Curtis, M.D.</u> | | DEGREE
<u>M.D.</u> | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
<u>DEC. 19, 1968</u> |
| 22d. PHYSICIAN'S NAME (Type)
<u>LEO M. CURTIS</u> | | 22e. ADDRESS
<u>8218 Wisconsin Ave. Bethesda, Mont. Md.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE
<u>12-22-68</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>All Saints Espc Ch</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Sunderland Calvert Md</u> | |
| 24. FUNERAL DIRECTOR
<u>Robert A Pumphrey Bethesda, Md</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 26 1968</u> | 25b. REGISTRAR'S SIGNATURE
<u>John Charles Judge</u> | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|------------------|--|---|---|--|---|--|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) <i>Marion Lee</i> | | | First <i>Lee</i> Middle <i>Compton</i> Last | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> <i>Dec 3</i> 1968 | | | 2b. HOUR <i>3:45</i> M | | |
| 3. SEX <i>M</i> | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>April 13-1923</i> | | 6. AGE (In years last birthday) <i>45</i> YRS | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | IF UNDER 24 HRS
HOURS <i></i> MIN. <i></i> | | 2c. DATE PRONOUNCED DEAD
Month <i>Dec</i> Day <i>3</i> Year <i>1968</i> | | 2d. HOUR <i>3:45</i> M | |
| 7a. BIRTHPLACE (State or foreign country) <i>D. C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Potomac</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8501 Buckhannon Dr. Potomac</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Accountant</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Self</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE <i>Maryland</i> | | | 13b. CITY OR TOWN <i>Potomac</i> | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>8501 Buckhannon Dr.</i> | | | |
| 14. FATHER'S NAME <i>Marion Lee Compton Sr.</i> | | | First <i>Lee</i> Middle <i>Compton</i> Last <i>Sr.</i> | | | 15. MOTHER'S MAIDEN NAME <i>Helma Harrison</i> | | | First <i>Helma</i> Middle <i>Harrison</i> Last <i>adone</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | | 16b. SOCIAL SECURITY NO. <i>4109</i> | | | 17. INFORMANT <i>Calista L. Compton</i> | | | ADDRESS <i>same as above</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial infarction, recent & old, left</i> | | | | | | | | | | <i>5 days.</i> | |
| DUE TO, OR AS A CONSEQUENCE OF <i>myocardium & septum</i> | | | | | | | | | | | |
| (b) <i>Coronary occlusion, right & left</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <i>Bevere coronary arteriosclerosis</i> | | | | | | | | | | | |
| (c) <i></i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <i>19</i> P.M. <i></i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | EXAMINER'S NAME (Type) <i>John G Ball</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <i>Dec 4, 1968</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>12-7-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Fairview Cemetery</i> | | 23d. LOCATION (City or Town) <i>West Hartford Conn.</i> | | (County) <i></i> | | (State) <i></i> | |
| 24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i> | | | | 25a. REC'D BY REGISTRAR <i>DEC 9 1968</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|---|---|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
BERYL B. CONKLIN | | | | | 2a. DATE OF DEATH
Month Day Year
12/ 21/ 1968 | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
6/28/90 | | 6. AGE (In years
lost birthday)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
Kansas | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
11503 Amherst Ave. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Ret. Reg. Nurse | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. CITY OR TOWN
Montgomery | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11503-Amherst Ave. | | | |
| 14. FATHER'S NAME First Middle Last
Francis B. Brown | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Alma Phelps Clark | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
579-20-1701 | | 17. INFORMANT
Beryl C. Kester 1509 Constance St.
Silver Spring, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>coronary arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Previous myocardial infarction Dec 1967</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Dec 21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Edward J. Pacious MD DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/21/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Edward J. Pacious | | | | | 22e. ADDRESS
1746 K St. N.W. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE
12/26/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Prince Georges County, Md. | | | |
| 24. FUNERAL DIRECTOR
The S.H. Hines Company
2901 14th St. N.W. Washington, D.C. | | | | | 25a. REC'D BY REGISTRAR
DEC 26 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 19. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|---------|--|--|--|---|---|---|-----------------------------------|------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| William Judson COPELAND | | | | | | Month Day Year | | 1968 955 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | |
| Male | Cauc. | 27 Jun 1948 | 20 YRS. | MONTHS | DAYS | HOURS | MIN. | Month Day Year | 1968 955 PM | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. COUNTY OF DEATH | | | | |
| Iowa | | USA | | NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Montgomery | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | Naval Hospital | | | Naval Cadet | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Iowa | | | | | Cedar Falls | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1833 Grand Blvd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Willis Dale Copeland | | | Nora A. Caley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes | | | 1967-1968 | | Mr. Willis Dale Copeland, 1833 Grand Blvd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>PENETRATING</u> Aspiration pneumonia, bilateral | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) <u>Subdural hematoma</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | | |
| 936.6 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| Dec 1, 1968 | | | Subdural Hematoma | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | 100 AM Nov 28 1968 | | Head injury playing football | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | Football field | | Mural Academy | | Annapolis | | Md. | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | |
| John G. Ball | | | M.D. | | | 12/5/68 | | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (Street, city, town, or county) | | | | |
| John G. Ball, M. D. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | | |
| Burial | | 12-9-68 | | Memorial Gardens | | Cedar Falls | | Iowa | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| W. W. Chambers Coward Chambers | | | | | | DEC 9 1968 | | J Charles Judge | | |
| 1400 Chapin Street, N. W. Washington, D.C. | | | | | | | | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|------------------|--|---|---|---|---|--|---|--|---|---------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | First
DONALD | | Middle
NMI | | Last
CORNELL | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year 12 9 68 | | 2b. HOUR
7:37 AM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
11-18-13 | | 6. AGE (In years last birthday)
53 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year 12 9 68 | | 2d. HOUR
7:37 AM |
| 7a. BIRTHPLACE (State or foreign country)
California, Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
teacher | | | 12b. KIND OF BUSINESS OR INDUSTRY
education | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Frederick | | | 13c. CITY OR TOWN
Frederick | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
114 East Church Street | |
| 14. FATHER'S NAME
First Middle Last
Harvey -- Cornell | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Elizabeth McDonald Cornell | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
YES | | | 16b. SOCIAL SECURITY NO.
(If give war or dates of service)
Yes | | | 17. INFORMANT
Anne Cornell (wife)
Caleffie Funeral Home Records
California, Penna. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4129</u> Acute coronary insufficiency;
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | Belden R. Keap M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
DEC 9 1968 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-12-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Highland Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
California Washington Pa. | | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 12 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judy | | | |

12111

RECEIVED BY THE DIRECTOR OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) JOSEPH H | | | First Middle Last M. COVEY | | | 2a. DATE OF DEATH December 31 1968 | | 2b. HOUR | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Nov. 10, 1915 | | 6. AGE (In years last birthday) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery | | Md. | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4821 Aspen Hill Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) X-Ray Tech. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 4821 Aspen Hill | |
| 14. FATHER'S NAME First Middle Last Marion Covey | | | 15. MOTHER'S MAIDEN NAME First Middle Last Bessie Aaron | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes, give war or dates of service) WWII | | 16b. SOCIAL SECURITY NO. 577-03-1368 | | 17. INFORMANT Address Ellen C. Covey - wife- same item # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction, recent and remote
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201
(b) Coronary insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(c) Severe Coronary arteriosclerosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 days
months
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Thrombosis Portal Vein, Post porta-caval shunt (Post surg. 2 months) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1, 1959 , to 12/31, 1968 , that (I) (we) lost the deceased on 12/31, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Stephen N. Jones DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/1/69 | | | |
| 22d. PHYSICIAN'S NAME (Type) STEPHEN N. JONES | | | | 22e. ADDRESS VIERS MILL ROAD - ROCKV, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/3/69 | | 23c. NAME OF CEMETERY OR CREMATORY Neelsville | | 23d. LOCATION (City or Town) (County) (State) Neelsville, Montg. Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Tyson Wheeler Funeral Home 1331 Rockville Pike | | | | 25a. REC'D BY REGISTRAR 6 DATE 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

17758

December 31 1968

Nov. 10, 1915

White

Male

Montgomery

U.S.A.

Marshall

X-Ray Tech.

1021 Apple Hill Road

Rockville

Montg.

MD.

Henrietta Larson

Marion Covey

273-03-1368 Miss C. Covey - wife - born 11-10-15

Yes

Married in 1940, present address as above

Married in 1940, present address as above

Married in 1940, present address as above

Married in 1940, present address as above (last name, 2 months)

Y

Rockville, Montg. Co.

Rockville

11/13/9

Married

Lyons Wheeler Funeral Home 131 Rockville Pike

Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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17738

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17749

| | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Lulu</i> | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year
<i>12 29 68</i> | | | 2b. HOUR
<i>1:45 PM</i> | | |
| 3. SEX
<i>FEMALE</i> | | | 4. RACE
<i>White</i> | | | 5. DATE OF BIRTH
<i>10/10/03</i> | | | 6. AGE (In years last birthday)
<i>65</i> YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>West Va</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Holy Cross</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MARYLAND</i> | | | 13b. COUNTY
<i>Mont.</i> | | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
<i>1200 Lockwood Dr.</i> | | | 14. FATHER'S NAME
First Middle Last
<i>John W. Crone</i> | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Clara M. Hunter</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<i>no</i> | | | 16b. SOCIAL SECURITY NO.
<i>-</i> | | | 17. INFORMANT
Address
<i>Brother Hendrix Edgewater Md</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Infarction, left hemisphere</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Rheumatic Heart Disease - Chronic Atrial Fibrillation</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>-</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
<i>398X</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>11 days</i>
<i>years</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>416X Pneumonia - atelectasis left lung</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 18, 1968</i> , to <i>Dec 29, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Gene U Cohen MD</i> DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>Dec. 29, 1968</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Gene U Cohen</i> | | | | | | 22e. ADDRESS
<i>Silver Springs, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE
<i>Jan 2, 1969</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>End of the Trail Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>East Rainelle Greenbrier West Va.</i> | | |
| 24. FUNERAL DIRECTOR
ADDRESS
<i>F. Gasch's Sons Hyattsville, Md</i> | | | 25a. REC'D BY REGISTRAR
DATE
<i>JAN 2 1969</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | |

July

Female

W.H. 4

West 1/4

X

Silver Spring

Holy Cross

Maryland

Silver Spring

1510 Jackson Dr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
<i>Phillip</i> | Middle
<i>--</i> | Last
<i>Crossfield</i> | 2a. DATE OF DEATH
Month <i>Dec.</i> Day <i>29</i> Year <i>1968</i> | | | 2b. HOUR
<i>10:30 P.M.</i> |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>2-26-1884</i> | | 6. AGE (In years last birthday)
<i>84</i> YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. |
| 7a. BIRTHPLACE (State or foreign country)
<i>Wash., D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>8505 Springvale Road</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)
<i>golf & painting office</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>golf t.</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Sil. Spr.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>8505 Springvale Road</i> | |
| 14. FATHER'S NAME
First <i>Jahiel</i> Middle <i>--</i> Last <i>Crossfield</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Cornelia</i> Middle <i>--</i> Last <i>Ellis</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<i>579-60-5319</i> | | 17. INFORMANT
<i>Elberta A. Crossfield</i> Address <i>Sil. Spr. Md. 8505 Springvale Rd.</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Congestive Heart failure</i>
<i>4129</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Coronary artery heart disease</i>
<i>4201</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3-4 years</i>

<i>years</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>60</i> , to <i>Dec 29</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Dec 29</i> , 19 <i>68</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Robert B. Drey</i> | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12-29-68</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Robert B. Drey</i> | | | | | 22e. ADDRESS
<i>11161 New Hampshire Avenue, Sil. Spr., Md.</i> | | | | |
| 23a. BURIAL CREATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>1-2-1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Lincoln Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Prince Georges, Maryland</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | | | | ADDRESS
<i>Sil. Spr., Md. 8434 Georgia Avenue</i> | | DATE
<i>JAN 6 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 17740 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17751 | | | | | | | | | |
|--|--|--|------------------------------|--|--|---|--|--|---------------------------------|---|--|--------------------------------|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH
Month Day Year | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| Paul T. Culbertson | | | | | | | | | | 12-18-68 | | | | | | | | | | 7:40 P M | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | | | | | | |
| m | | | White | | | 4/11/1897 | | | 71 YRS. | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| PENNA. | | | U.S.A. | | | | | | MONTGOMERY Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| DARNESTOWN | | | | | RT. #28 | | | | | FOREIGN SERVICE - U.S. Govt. | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| MD. | | | | | MONTGOMERY | | | | | DARNESTOWN | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | RT. #28 | | | | | | | | | |
| 14. FATHER'S NAME
First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| GEORGE G. CULBERT | | | | | SARA SMITH | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
Address | | | | | | | | | | | | | | | | | | | |
| YES | | | | | W. W. I | | | | | 577-56-1117 MARIA B. CULBERTSON - SAMEAS 13-E | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Glomerular Nephritis
582X
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
592X | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 years | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic Brain Syndrome and Early Cirrhosis of Liver | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct, 19 67, to 18 Dec, 19 68, that (I) (we) last saw the deceased alive on 18 Dec 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Gordon Murdoch Smith, MD | | | | | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
19 Dec 68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Gordon Murdoch Smith, MD | | | | | | | | | | 22e. ADDRESS
Boyd's, Md 20720 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL OR CREMATION
XXXXXX | | | | | 23b. DATE
12-21-68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Darnestown Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Darnestown Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey Bethesda, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 6 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | |

17521

Albertson

4/11/89

White

Mr



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "The" and "of" are visible.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 17741 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 17752 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
<i>Loyce</i> | | | Middle
<i>Enloe</i> | | | Last
<i>Davis</i> | | |
| 3. SEX
<i>Female</i> | | | 4. RACE
<i>White</i> | | | 5. DATE OF BIRTH
<i>Nov. 4, 1887</i> | | | 2a. DATE OF DEATH
Month <i>Dec.</i> Day <i>3</i> Year <i>1968</i> | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Missouri</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Montgomery</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>Chevy Chase</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>3802 Thornapple Street</i> | | | 12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.)
<i>Wife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>own home</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | | 13b. COUNTY
<i>Montgomery</i> | | | 13c. CITY OR TOWN
<i>Ch. Chase</i> | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
First <i>Isaac</i> Middle <i>-</i> Last <i>Enloe</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Rebecca</i> Middle <i>--</i> Last <i>Short</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>24-46-6400</i> | | |
| 17. INFORMANT
<i>Roy Josco Davis</i> | | | Address <i>3802 Thornapple Street</i> | | | City <i>Ch. Ch.</i> State <i>Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>One of Arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 days</i>
<i>39 hrs.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>4221</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>August 2, 1943</i> , to <i>Dec 3, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 2, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>12/3/68 3:25AM</i> | | | | | | | | | | | |
| 22b. SIGNATURE
<i>W B Wardrop MD.</i> | | | DEGREE
<i>MD.</i> | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE/SIGNED
<i>12/3/68</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>William B. Wardrop</i> | | | 22e. ADDRESS
<i>808 Pershing Drive, Silver Spring, Md.</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
<i>12-6-1968</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rock Creek Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Washington, D. C.</i> | | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | | ADDRESS
<i>8434 Georgia Avenue</i> | | | 25a. REC'D BY REGISTRAR
<i>DEC 3 1968</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>James Judge</i> | | |

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7. *Journal of the American Medical Association*, 283: 2623-2628, 2000.

101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-109

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100-1-54

0-243-2

17742

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(Type or print) RENÉE T. DAVIS | | | 2a. DATE OF DEATH
Month DEC Day 27 Year 1968 | | | 2b. HOUR 8:30 AM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
7/17/1887 | | 6. AGE (In years last birthday)
81 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
California | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GROSVENOR LANE NURSING HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | 13b. COUNTY
----- | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
3900 Cathedral Ave., N.W. | | 14. FATHER'S NAME First Middle Last
Wilbur -- Tolson | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary -- Rogers | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Roger Davis, Son, 1621 Overlea Rd., Wash., D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
485X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
491X
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
± 1 WK. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CEREBRAL VASCULAR DISEASE - CHRONIC BRAIN SYNDROME | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1946 , to DEC 27, 1968 , that (I) (we) last saw the deceased alive on DEC 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
H D Ecker MD. | | DEGREE MD. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/27/68 | |
| 22d. PHYSICIAN'S NAME (Type)
HENRY D. ECKER MD | | 22e. ADDRESS
916-19th St. N.W. - WASH. D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
12/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS
Joseph Gawler's Sons, 5130 Wis. Ave. NW, Wash., DC | | | | 25a. REC'D BY REGISTRAR
JAN 2 1969 | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7

RECEIVED

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH
2-14-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17743

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17754

| | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|-----------------|--|--|---|--|---|-------------|--|--|---|--|---|-------------------|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First
GLADYS | | | Middle
JEAN | | | Last
DAY | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year
12-9-68 | | | 2b. HOUR
M | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
9/11/42 | | 6. AGE (in years
last birthday)
26 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year
12 9 68 | | | 2d. HOUR
9:15p | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
New York | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Wash. San. & Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Homemaker | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | | | 13b. COUNTY
P.G. | | | | 13c. CITY OR TOWN
Adelphi | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2402 Metzertott Rd. | | | | | | | |
| 14. FATHER'S NAME
First Middle Last
W. Albert Wright | | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Margaret E. Clineman | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | | 17. INFORMANT
ADDRESS
Family of Deceased | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gunshot wound in head with cerebral</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>laceration and exsanguination.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>981X</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR:MIN
9:00 P.M. 12-9 1968 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>Deceased apparently shot in head
by husband</u> | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
Home | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<u>2402 Metzertott Rd. Adelphi Pr. Geo. Md.</u> | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
<u>Belden R. Reap</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county)
<u>BELDEN R. REAP, M.D., BALTIMORE</u> | | | | 22b. DATE SIGNED
<u>Dec. 10, 1968</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<u>Burial</u> | | | | 23b. DATE
<u>Dec. 13, 1968</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetery</u> | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Berrien Spring Michigan</u> | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>J. Arthur Walters, 257 Carroll St. NW - LAC</u> | | | | | | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR
<u>DEC 12 1968</u> | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | | | |

11750

UNITED STATES DEPARTMENT OF AGRICULTURE

11750

11750



11750

11750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper No. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

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| 17744 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 17755 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Hortense Harris Degen | | | | | | | | | | | | 2a. DATE OF DEATH
Month Day Year
12 16 68 | | | | | | | | | | | | 2b. HOUR
7:35 A.M. | | | | | | | | | | | |
| 3. SEX
Female | | | | 4. RACE
Cauc. | | | | 5. DATE OF BIRTH
April 11, 1914 | | | | 6. AGE (In years
last birthday)
54 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | IF UNDER 24 HRS
HOURS MIN. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
New York | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery Md | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Nsg. Home 1000 Daleview Dr. | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Own Home | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
N.Y. | | | | 13b. COUNTY
Hudson | | | | 13c. CITY OR TOWN
W. N.Y. | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
6050 Kennedy Blvd. E. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First Middle Last
Leopold Harris | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Sadie (unknown) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
051-01-7050 | | | | 17. INFORMANT
Address
Eugenia Henn 570 N St., S.W., Wash., D.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Metastasis Carcinoma
174X DUE TO, OR AS A CONSEQUENCE OF:
Carcinoma Breast.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF:
(c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6+ yrs.
7 yrs. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
170X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
170X | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 68 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)
N.Y. | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 1968, to 16 DEC 1968, that (I) (we) last saw the deceased alive on 15 DEC 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
A. H. Richwine MD | | | | | | | | | | | | 22c. PHYSICIAN'S NAME (Type)
A. H. RICHWINE, MD. | | | | 22d. ADDRESS
5222 Western Ave Chevy Chase, Mont. MD. | | | | 22e. DATE SIGNED
1968 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
12-19-1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Hungarian Union Fields Cem. Brooklyn, New York | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Carter | | | | ADDRESS
Sil. Spr. Md. | | | | 25a. REC'D BY REGISTRAR
DATE DEC 23 1968 | | | | 25b. REGISTRAR'S SIGNATURE
K. Charles Judge | | | | | | | | | | | | | | | | | | | | | | | |

17755

TECHNICAL OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17745 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17756 | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|---|--|---|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First MIDDLE LAST
BERTHA HENRIETTA DEMAR | | | | | | | | | | Month 12 Day 26 Year 68 | | | | | | | | | | 9:00 AM | | | | | | | | | |
| 3. SEX
FEMALE | | | 4. RACE
NEGROE | | | 5. DATE OF BIRTH
8-27-98 | | | 6. AGE (In years last birthday)
70 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
OLNEY | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MONTGOMERY GENERAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
RETIRED | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | | 13c. CITY OR TOWN
GAITHERSBURG | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
RT.#1 | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First MIDDLE LAST
JAMES STEWART | | | 15. MOTHER'S MAIDEN NAME First MIDDLE LAST
ANNIE STEWART | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | 17. INFORMANT
Address | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intra-Cranial Hemorrhage</u>
4120 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>H.C.V.D.</u>
(b) <u>H.C.V.D.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
17 days
4 years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u>58</u> , to <u>Dec. 24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec. 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jack Schumacher</u> | | | 22c. DATE SIGNED
12-27-68 | | | 22d. PHYSICIAN'S NAME (Type)
George R. Snowden | | | 22e. ADDRESS
Rockville | | | 22f. REGISTERED BY REGISTRAR
DATE JAN 3 1969 | | | 22g. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
12-31-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
BROOKE GROVE Cem. | | | 23d. LOCATION (City or Town) (County) (State)
Laytonsville Montg Md. | | | | | | | | | | | | | | | | | | | | |

17758

MINISTRE DU TRAVAIL

17758

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1968

MAR 8

FOR STATE HEALTH DEPT.

17746

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17757

| | | | | | | | | | |
|---|-------------------------|--|---|---|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or Print) <i>Bartholomew A. Higgins</i> | | | 2a. DATE KNOWN OF DEATH
Month <i>12</i> Day <i>23</i> Year <i>1968</i> | | | 2b. HOUR OF DEATH
M <i>8:15</i> AM | | | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
<i>7-6-8-1908</i> | 6. AGE (In years last birthday)
<i>60</i> YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN | 2c. DATE PRONOUNCED DEAD
Month <i>Dec</i> Day <i>23</i> Year <i>1968</i> | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>WASH. D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Montgomery</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>D.A.H. - SUBURBAN HOSP.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>ATTORNEY</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>LAW</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Kensington</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>9716 W Beekhill Dr</i> | |
| 14. FATHER'S NAME
First <i>DAVID</i> Middle <i>FARRAGUT</i> Last <i>DIGGINS</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>MARGARET</i> Middle <i>COLEMAN</i> Last <i>COLEMAN</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <i>NO</i> | | | |
| 16b. SOCIAL SECURITY NO.
<i>013-03-8668</i> | | | 17. INFORMANT
ADDRESS
<i>MONTA DIGGINS-WIFE - SAME AS #13</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Exsanguination</i>
<i>956X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Laceration of Jugular vein.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5-12-17.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>9716</i> | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>12/23/68</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
<i>Cut Jugular vein. c Knife</i> | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
<i>7:05 PM 12/23/1968</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<i>Cut Jugular vein. c Knife</i> | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
<i>Home</i> | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<i>9716 W Beekhill Dr Kensington Mont. Md</i> | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
<i>Dec. 23, 1968.</i> | | | |
| EXAMINER'S NAME (Type)
<i>John G. Ball</i> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county)
<i>Montg. Co., Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>12/27/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Olivet Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Washington, D.C.</i> | | 24. FUNERAL DIRECTOR
<i>Jos. Gawler's Sons, 5130 Wis. Ave, NW, Wash., D.C.</i> | |
| 25a. REC'D BY REGISTRAR
<i>DEC 30 1968</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

42371

1

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17717

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17758

| | | | | | | | | | | | | | | |
|---|---------|------------------|--|--|-----------------------|--|----------------------|--|-----------------------------------|--|---------------------|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year | | | 2b. HOUR | | | | | |
| Alfred | | | D. | | | Donnaud | | | Dec. 25 1968 | | | 420 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS. DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | |
| M | Cau | 10/2/93 | 75 YRS. | | | | | Month Day Year | | | Dec. 25 1968 420 PM | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | |
| Louisiana | | | U.S. | | | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Silver Spring | | | Holy Cross | | | Advertising - Retired | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET AND NUMBER | | | | | |
| Louisiana | | | New Orleans | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1205 St. Charles Ave. | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | |
| Albert -- Donnaud | | | Siddie Ciddie -- Dawkins | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | |
| yes | | | WWI | | | 490-03-0485 | | | John Donnaud, 11400 Lovejoy St. | | | Wheaton | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEC. 25, 1968 | | | | | | |
| Belden R. Reap, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | |
| | | | | ADDRESS (Street, City, Town, or County) | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | |
| Burial | | | | 12-28-1968 | | | | Greenwood Cemetery | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 23d. LOCATION (City or Town) (County) (State) | | | | 25a. REC'D BY REGISTRAR | | | | | | |
| Warner E. Pumphrey, Inc. | | | | New Orleans, Louisiana | | | | DATE DEC 30 1968 | | | | | | |
| | | | | ADDRESS Sil. Spr., Md. | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| | | | | 8434 Georgia Avenue | | | | J. Charles Judge | | | | | | |

NAME _____

CONCLUSION

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Inventory

4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 10

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John Deane, 11400 Beverly St.

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002 0 6 330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1-64

MEDICAL CERTIFICATION

| 17748 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17759 | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| Edward Auguste Dove | | | | Dec. 17 1968 | | | | 5 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| M | | W | | April 23 1908 | | 68 YRS. | | MONTHS | | OAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | |
| WASH. D.C. | | U.S.A. | | NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | MONTGOMERY | | WHEATON | | 12063-CHARLES RD. | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. CITY OR TOWN | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? | | 13d. STREET AND NUMBER | |
| MECHANIC | | AUTO. | | WHEATON | | MONTGOMERY | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12063-CHARLES RD. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| JAMES H. Dove | | MARIONNET A. Dove | | NO | | | | Family | | 13E | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Coronary occlusion | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Atherosclerotic heart disease | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4201 Kmp 65 and | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | City or Town | | County | | State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1956, 19, to 12/17 1968, that (I) (we) last saw the deceased alive on 12/17 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | | | | |
| John B. Umhau | | | | 12/17/68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | |
| JOHN B. UMHAU | | | | 8805 Conn. Ave. Chevy Chase Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| REMOVAL | | 12/20/68 | | GATE OF HEAVEN | | 5L. SPRING | | | | D.C. | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| HANTON FUNERAL HOME - WASH. D.C. | | | | DATE DEC 23 1968 | | | | HANTON | | | |

11558

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17749

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17760

| | | | | | | | | |
|--|--|---|--|---|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) THOMAS C. DOWNES SR | | | 2a. DATE OF DEATH
Month DEC Day 30 Year 1968 | | | 2b. HOUR
6:15 A | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
JULY 6, 1902 | | 6. AGE (In years last birthday)
66 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS HOSPITAL VAULT | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
BURIAL VAULT | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD | | | 13b. COUNTY
MONTG. ROCKVILLE | | 13c. CITY OR TOWN
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
505 GILSCOTT PL. | |
| 14. FATHER'S NAME First OLIVER E. Middle BOWNES Last DOWNES | | | 15. MOTHER'S MAIDEN NAME First JULIA Middle DULEY Last DOWNES | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
579-07-5001 | | 17. INFORMANT
THOMAS DOWNES JR. Address 807 LYNWOOD CT ROCKVILLE MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) None.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
None. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Few hours
Several months | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Sept. | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
None | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Sept. 1968 | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 1968 , to Dec 30, 1968 , that (I) (am) last saw the deceased alive on Dec 20, 1968 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Lynwood Heiges M.D. | | | | 22c. DATE SIGNED
12/30/68 | | 22d. PHYSICIAN'S NAME (Type)
LYNWOOD HEIGES | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/2/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Potomac | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler F. H. | | | | 25a. REC'D BY REGISTRAR
JAN 3 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

17758

DEPARTMENT OF HEALTH

RECEIVED - JAN 3 1968

CHANDLER ROBERT L. JR.
1015 N. 1st St.
Tulsa, Oklahoma 74103

Postmark

1/2/68

Postage

Ysop, Doctor L. H. 1961
Rockville, Maryland
JAN 3 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-1
30M RE 1-1-68

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|--|--|
| 17750 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 17761 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Edward Middle Harry Last Drummer | | | | | | | | | | | | 2a. DATE OF DEATH Month December Day 2, Year 1968 | | | | | | | | | | | | 2b. HOUR MIN 4:15 PM | | | | | | | | | | | |
| 3. SEX Male | | | | 4. RACE Negro | | | | 5. DATE OF BIRTH 9 July 1957 | | | | 6. AGE (In years last birthday) 11 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student | | | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. COUNTY Queen Annes | | | | 13c. CITY OR TOWN Stevensville | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER No street address | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Edward Middle Drummer Last | | | | 15. MOTHER'S MAIDEN NAME First Emma Middle Bordley Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | | | 16b. SOCIAL SECURITY NO. None | | | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis with bronchopneumonia, left upper lobe 2040
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphocytic Leukemia
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
2043 Pancreatic fat necrosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from August 12, 1968, to December 2, 1968, that (b) (we) last saw the deceased alive on December 2, 1968, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Harmon J. Eyre MD | | | | 22c. DATE SIGNED 3 December 1968 | | | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Harmon J. Eyre, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 12-5-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY BATTIS NECK | | | | 23d. LOCATION (City or Town) BATTIS NECK (County) QUEEN ANNE (State) MARYLAND | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR BARBARA L. DASHIEN | | | | 426 DOVER ADDRESS ST. EASTON, MARYLAND | | | | 25a. REC'D BY REGISTRAR DEC 5 1968 | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17751

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17762

CERTIFICATE OF DEATH

| | | | | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--------------------------------|--|------------------------------|--|
| 1. DECEASED NAME
(Type or print) Bennie | | | First Middle Last
R. ECHWALD | | | 2a. DATE OF DEATH
Month Day Year
December 4, 1968 | | | 2b. HOUR
745P | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
May 14, 1921 | | | 6. AGE (In years last birthday)
47 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Oklahoma | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 1d. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
U. S. Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Real Estate Saleswoman | | | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Virginia | | 13b. COUNTY
Fairfax | | 13c. CITY OR TOWN
Fairfax | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3201 Sydenham Street | | | | |
| 14. FATHER'S NAME
First Middle Last
Unknown | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Bennie Allen MILSTEAD | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | 16b. SOCIAL SECURITY NO.
440-12-2228 | | 17. INFORMANT
USAF LTCOL. Walter ECHWALD RET. | | | Address 1300 Army-Navy Dr. Arlington, Va. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the breast with widespread metastases
174X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
170X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 3, 1968 to December 4, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 4, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
D. L. Colgan | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
6 December 1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
D. L. COLGAN M.D. | | | | | | 22e. ADDRESS
U. S. NAVAL HOSPITAL, Bethesda, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-9-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | | | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY FUNERAL HOME | | | | | | 25a. REC'D BY REGISTRAR
DEC 9 1968 | | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | | | | |
| 7557 Wisconsin Ave., Bethesda, Maryland | | | | | | | | | | | | |

17782

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| Item 13 Film 407 12/16/68 17752 | | | | | | | | | | | | |
|--|--|--------------|--|------------------------------------|--|---|--|--|--|---|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
GEORGE M EDWARDS | | | | | | 2a. DATE OF DEATH Month Day Year
DECEMBER 4 1968 | | | | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
OCT. 23 - 1896 | | | 6. AGE (In years lost birthday)
72 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS | | 8. UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
POTOMAC MOUNT CO | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
COLONIAL VILLA | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
CARPENTER (RETIRED) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11477 Old Columbia Pike | | |
| 14. FATHER'S NAME First Middle Last
GEORGE W. EDWARDS | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ELLA GRAY | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
NO | | | | | | |
| 16b. SOCIAL SECURITY NO.
220-01-2029 | | | 17. INFORMANT Address
MELORED A. EDWARDS 11477 Old Columbia Pike S.S.M.D. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | |
| (b) <u>Congestive Heart Failure</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
4200 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug, 1963, to 12/4, 1968, that (I) (we) last saw the deceased alive on 12/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Joseph E. Smith, Jr. | | | DEGREE
ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | 22c. DATE SIGNED
12/4/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Joseph E. Smith, Jr. | | | 22e. ADDRESS
Bartonsville, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
DECEMBER 7 - 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Andrews | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | | 23e. REGISTRAR'S SIGNATURE
Charles Judge | | |
| 24. FUNERAL DIRECTOR
Arthur Kellers | | | ADDRESS
254 Carroll St | | 25a. REC'D BY REGISTRAR
DATE
DEC 9 1968 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

13763

DEPARTMENT OF AGRICULTURE

April 13, 1913

Washington, D.C.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 11th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

John D. Sweeney, Chief

Executive Secretary

Department of Agriculture

Washington, D.C.

Very truly yours,

John D. Sweeney

Chief Executive Secretary

Department of Agriculture

Washington, D.C.

Very truly yours,

John D. Sweeney

Joseph E. Smith, Jr.

President of the Church

Salt Lake City, Utah

Very truly yours,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|---|---|---|---|--|--|---|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 17753 CERTIFICATE OF DEATH 17764 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Sarah</i> | | | First Middle Last <i>Ettelman</i> | | | 2a. DATE OF DEATH
Month <i>12</i> Day <i>9</i> Year <i>68</i> | | 2b. HOUR
<i>11:00 A.M.</i> | | | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>1893</i> | | 6. AGE (In years last birthday)
<i>75</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>ROMANIA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>MONTGOMERY</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>TAKOMA PARK</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>WASH. SAN.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>HOUSEWIFE</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>-</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>1001 Spring St. #622</i> | | |
| 14. FATHER'S NAME
<i>ABRAHAM</i> | | | First Middle Last <i>SHAPIRO</i> | | | 15. MOTHER'S MAIDEN NAME
<i>UNIKOVICH</i> | | | First Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <i>NO</i> | | | 16b. SOCIAL SECURITY NO.
<i>578-28-5145</i> | | | 17. INFORMANT
<i>BENJ. ETTLEMAN</i> | | | Address
<i>9224 REVELLE DR NEC</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Sclerosis</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 hr.</i>
<i>6 hr.</i>
<i>10 years</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY
(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>June 11</i> , 19 <i>65</i> , to <i>12/9</i> , 19 <i>68</i> , that (1) (we) last saw the deceased alive on <i>12/9</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Max G. Sherer MD</i> | | | | DEGREE
<i>MD</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/9/68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>MAX G. SHERER</i> | | | | 22e. ADDRESS
<i>800 Pershing Dr. Silver Spring, Md</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>12/11/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>D.C. Lodge Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>WASH DC</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Goodman Funeral Home</i> | | | | ADDRESS
<i>4217 9th Ave</i> | | 25a. REC'D BY REGISTRAR
<i>DEC 13 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|---------|--|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 17765 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| ROBERT | | | L. EVANS | | | Month Day Year
12/ 10 68 | | | P
12:40 |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| Male | Cau. | | 4/4/96-1900 | | | 72 68 YRS. | | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Texas | | | U.S.A. | | | | Montgomery Co. Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda, Maryland | | | Grosvenor Lane Nursing Home | | | Retired Broker | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Washington, D.C. | | | D.C. | | Washington | | YES | | 1300 Somerset Pl., N.W. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Richard | | | Evans | | | Adelia Smith | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| Yes | | | 4/29/18 3/17/19 577 50/ 7571 | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxiation and asphyxiation</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic carcinoma of stomach</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Syphilis</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>144x</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>68</u> , to <u>Dec 10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>David Burrows, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS <u>9237 30th Silver Spring</u> | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| | | 12-14-68 | | Lincoln | | Baltimore Md | | | |
| 24. FUNERAL DIRECTOR <u>Progen 389 B.I. one new work etc</u> | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | DATE | | <u>DEC 16 1968</u> <u>Charles Judge</u> | |

1978

(UNITED STATES)

1978

OFFICE OF THE
DIRECTOR
OF THE
BUREAU OF
THE
CENSUS

OFFICE OF THE
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CENSUS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|-----------------------------------|--|-------------------------------------|--|
| 1. DECEASED-NAME (Type or print) ROXXX ROXIE P. FARRAR | | | | | | | | | | 2a. DATE OF DEATH
Month 12 Day 31 Year 68 | | | | 2b. HOUR 10 35 MIN AM | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 4/30/64 | | | | 6. AGE (In years last birthday) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 13009 VANDALIA DRIVE | | | | | |
| 14. FATHER'S NAME First Richard P. Middle Dodd Last Dodd | | | | 15. MOTHER'S MAIDEN NAME First Myrtle Middle ? Last ? | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 230-20-2220 | | 17. INFORMANT Henry T. Farrar -Item # 13 | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
490X | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/24 , 19 68 , to 12/31 , 19 68 , that (I) (we) last saw the deceased alive on 12/31/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Travis X Richmond | | 22c. DATE SIGNED 12/31/68 | | 22d. PHYSICIAN'S NAME (Type) Travis X Richmond | | | | | | | | | | | |
| 22e. ADDRESS 11412 Veers Mill Road Silver Spring, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit | | 23b. DATE 1/4/69 | | 23c. NAME OF CEMETERY OR CREMATORY Hebron Baptist | | | | 23d. LOCATION (City or Town) (County) (State) Avon, Virginia | | | | | | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike | | 25a. REC'D BY REGISTRAR JAN 6 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | |
| Rockville, Maryland | | | | | | | | | | | | | | | |

1376

STATE OF TEXAS

IN SENATE

January 10, 1901

REPORT

OF THE

COMMISSIONER

OF THE LAND OFFICE

FOR THE YEAR 1900

1901

X

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17756 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17767 | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|--|---|--|--------------------------------|---|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Mary</i> <i>D</i> <i>Finch</i> | | | | | | | | | | 2a. DATE OF DEATH
Month <i>Dec</i> Day <i>2</i> Year <i>1968</i> | | | | | | | | | | 2b. HOUR
<i>8:45 A.M.</i> | | | | | | | | | |
| 3. SEX
<i>female</i> | | | 4. RACE
<i>Caucasian</i> | | | 5. DATE OF BIRTH
<i>5-21-1881</i> | | | 6. AGE (In years last birthday)
<i>87</i> YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>North Carolina</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Kensington</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Kensington Gardens N.H.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>At home</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | | 13c. CITY OR TOWN
<i>Chevy Chase</i> | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
<i>3601 Husted Drive</i> | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First <i>Joshua</i> Middle <i>Deans</i> Last <i>Vick</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Mary</i> Middle <i>Eliza</i> Last <i>Vick</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <input type="checkbox"/> (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO.
<i>-</i> | | | 17. INFORMANT
Address <i>Chase, Maryland</i>
<i>F. Irvin Finch, Sons, 3601 Husted Dr., Chevy</i> | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>
<i>4100</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i>
(b) <i>myocardial Ischemia & decompensated heart</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Hypertensive heart disease</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 hrs.</i>
<i>2 months.</i>
<i>12 years.</i> | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Generalized Arteriosclerosis & psychosis - Decubitus Buttocks.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/27</i> , 19 <i>67</i> , to <i>12/2</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/20</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Sherman A. Thomas</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
<i>12/2/68</i> | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Sherman A. Thomas</i> | | | | | | | | | | 22e. ADDRESS
<i>4301 48th St N.W. Wash. D.C.</i> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
<i>12-4-1968</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Maplewood Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Wilson, North Carolina</i> | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Joseph Gawler's Sons, Inc.,</i> | | | | | | | | | | ADDRESS
<i>5130 Wisc. Ave. N.W., Wash., D.C., 20016</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>DEC 5 1968</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Young</i> | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|------------------------------|--|--|--|--|---------------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| RHODA | | | MYRTLE | | | FINK | | | Month 12 Day 2 Year 68 105 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| Female | | White | | Feb. 5, 1895 | | | 73 YRS. | | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| W. VA. | | U.S.A. | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Takoma Park | | | WASH. SAN Hosp. | | | Counselor | | | Home Receiving | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Maryland | | | Montgomery | | | W. Hyatts | | | 1800 Drexel St. Baltimore | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| ISRAEL | | | Getz | | | JANE Sites | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| NO | | | 216-46-7776 | | | Carlton Fink 8303 26th Place, | | | Maryland Adelphi | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | 6 mo. | |
| IMMEDIATE CAUSE (a) Generalized Carcinomatosis | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Bronchogenic Carcinoma | | | | | | | | | | 3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 1621 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | / | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | City or Town County State | | |
| | | | | | | Street or R.F.D. No. | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to Dec 1, 1968, that (I) (we) last saw the deceased alive on Dec 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| Robert B. Irax | | | | | | | | | 12-2-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| ROBERT B. IRAX | | | | | | 11161 New Hampshire Ave S.S. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 12-4-1968 | | | St. Luke Lutheran Cemetery | | | Derwood Montgomery Md. | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| M. Andrew Duwall Warner E. Pumphrey, Inc. 8434 Georgia Ave. | | | | | | DEC 6 1968 | | | Charles Judge | | |

JAN 1968

DIVISION OF INVESTIGATION

WASHINGTON, D.C.

TO :

FROM :

SUBJECT :

RE :

DATE :

BY :

CLASS :

FILE :

NOTE :

REMARKS :

ACTION :

DISPOSITION :

STATUS :

COMMENTS :

REMARKS :

ACTION :

STATUS :

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REMARKS :

ACTION :

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 1/68
45M - 1/68

| 17753 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17769 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--------------------------------|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH
Month Day Year | | | | | 2b. HOUR
12 No. M | | | | | | | | | | | | | | |
| PAULINE | | | | | FINKEL | | | | | Dec 20 1968 | | | | | 12 No. M | | | | | | | | | | | | | | |
| 3. SEX
FEMALE | | | | | 4. RACE
WHITE | | | | | 5. DATE OF BIRTH
6/18/85 | | | | | 6. AGE (In years last birthday)
83 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | | IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
WASHINGTON, D.C. | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Montgomery | | | | | Md | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SUBURBAN | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
NONE | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | | 13b. CITY OR TOWN
BETHESDA | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
9921 JULIARD DRIVE | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
MORRIS | | | | | 15. MOTHER'S MAIDEN NAME
ROSE | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | | | 17. INFORMANT
RICHARD FINKEL SON | | | | | Address | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma, lungs</u>
1621
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
163X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 9, 1968, to Dec. 20, 1968, that (I) (we) last saw the deceased alive on Dec. 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Richard H. Pollen MD | | | | | | | | | | | | | | | 22c. DATE SIGNED
12/20/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
RICHARD H. POLLEN MD | | | | | | | | | | | | | | | 22e. ADDRESS
10400 CONNECTICUT AVE, KENSINGTON, MD | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
cremation | | | | | 23b. DATE
23 Dec 68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | | | 23d. LOCATION (City or Town) (County) (State)
Suitland Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawlers Sons | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 27 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | |
| 5130 Wisc. Ave. N. W. Wash D. C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) YETTA | | | | | | First | | Middle | | Last | |
| 2. DATE OF DEATH
Dec. 31, 1968 | | | | | | Month | | Day | | Year | |
| 3. SEX
Female | | | | | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
6-15-1894 | | 6. AGE (In years last birthday)
74 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
University Nursing Home | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WASH - D.C. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
D.C. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1336 Missouri Ave - N.W. | |
| 14. FATHER'S NAME
JOSEPH | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME
Leath | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Nathan Fishkin | | Address
1336 Missouri Ave, N.W. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchio-Pneumonia
471X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 480X
(b) Probably Influenza
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Diabetes Mellitus; Congestive Heart Failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/31 , 19 68 , to 12/31 , 19 68 , that (I) (we) last saw the deceased alive on 12/31 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Samuel Dessoff M.D. | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/31/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
SAMUEL DESSOFF | | | | 22e. ADDRESS
302-18th St. N.W. Wash. D.C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 2, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Ohev Shalom-Talmud Torah | | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
Bernard Danzowsky & Sons | | | | ADDRESS
3501-14th St. N.W. Washington, D.C. | | 25a. RECEIVED BY REGISTRAR
JAN 6 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

17770

RECEIVED

APR 12 1964

17770

WINTER 1964

POST OFFICE BOX 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When page 3 is detached, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17760 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|---|---|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | 17773 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Emma | | | | | First - Middle Fitch Last | | | | | 2a. DATE OF DEATH
Month DECEMBER Day 22 Year 1968 | | | | | 2b. HOUR
9:28 P. M. | | | | | |
| 3. SEX
FEMALE | | | 4. RACE
CAUC. | | | 5. DATE OF BIRTH
7/1/1882 | | | 6. AGE (In years last birthday)
86 YRS. | | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | | IF UNDER 24 HRS.
HOURS 0 MIN 0 | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
CANADA | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING, MD. | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ALTHEA WOODLAND NURSING HOME 1000 BAILEY DRIVE - S. SPRING | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C. | | | | | 13b. COUNTY
WASHINGTON | | | | | 13c. CITY OR TOWN
WASHINGTON | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
2500 Q St. N.W. | | | | |
| 14. FATHER'S NAME First SIGURTHUR Middle GOODMAN Last GOODMAN | | | | | 15. MOTHER'S MAIDEN NAME First SIGURLAUG Middle GUNNA Last DOTTIR | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO.
577-68-699 | | | | | 17. INFORMANT
MISS EVELYN FITCH, DAUGHTER, SAME AS #13 Address | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Artery thrombosis
4339 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 days
5 years | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
332X | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 20, 1959 , to Dec 23, 1968 , that (I) (we) last saw the deceased alive on Dec. 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Frank S. Bacon M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
Dec. 23, 1968 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
FRANK S. BACON, M.D. | | | | | | | | | | 22e. ADDRESS
2141-K-Street N.W. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal-Burial | | | | | 23b. DATE
12-24-1968 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Elmwood Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Winnepeg, Manitoba, Canada | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | | | | | | | | | 25a. REC'D BY REGISTRAR
DEC 27 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | |

10771

RECEIVED



RECEIVED

DEC 1 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and (where filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER NOTIFIED AND APPROVES

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--------------------------------|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--|--|
| Item2 Film408 1/17/69 kk | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 17772 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Agnes Marion Foreman | | | | | | | | | | | | 2a. DATE OF DEATH
Month Day Year
12 16 68 | | | | | | | | | | | | 2b. HOUR
6:10 PM | | | | | | | | | | | |
| 3. SEX
Female | | | | 4. RACE
White | | | | 5. DATE OF BIRTH
11-13-98 | | | | 6. AGE (In years
last birthday)
70 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) Wash. D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Wash. San & H Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
HOUSEWIFE | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE, CITY, COUNTY
Md. PRINCE GEORGES | | | | 13c. CITY OR TOWN
Lewisdale | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
2259 Hannon St. | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
SIMMONS | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sarah BOLAND XXXXXXXX | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
577-07-2583 | | | | 17. INFORMANT
son & daughter | | | | Address | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u>
4120 DUE TO, OR AS, A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC VASCULAR DIS.</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
IMMED. | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>63</u> , to <u>Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Bernard A. Fitzgerald MD</u> | | | | | | | | | | | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-16-68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) <u>BERNARD A. FITZGERALD</u> | | | | | | | | | | | | 22e. ADDRESS
<u>217 UNIV. BLVD. E., SILVER SPRING, MD.</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
BURNING (Specify)
BURIAL | | | | 23b. DATE
12-19-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
MT. OLIVET CEMETERY | | | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON, D. C. | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>COLLINS FUNERAL HOME</u> ADDRESS <u>500 UNIV. BLVD. W. SILVER SPRING, MARYLAND.</u> | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 20 1968</u> | | | | 25b. REGISTRAR'S SIGNATURE
<u>J Charles Judge</u> | | | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-glue carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|--|---|--|--------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Vida Ann Fortner | | | | | 2a. DATE OF DEATH
12 Month 12 Day 68 Year | | 2b. HOUR
649 M | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
4-5-83 | | 6. AGE (In years last birthday)
85 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
American U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San + Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
HOUSEWIFE | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince George | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2308 Erskine St. | |
| 14. FATHER'S NAME First Middle Last
Perry | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Barley Mary Bell | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT Address
Mrs. Louise Riffe, 2308 Erskine St. Hyattsville Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary embolism | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Post of barrel resection for | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) obstructed obstetric disease | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
5615 Uremia, Parkinsonism. | | | | | | | | | |
| 19a. DATE OF OPERATION
12/4/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Obstructed obstetric disease | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19
12/12/68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1 , 19 68 , to 12/12 , 19 68 , that (I) (we) last saw the deceased alive on 12/12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Norman H. Isaacson M.D. | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/13/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
NORMAN H. ISAACSON, M.D. | | 22e. ADDRESS
SILVER SPRING, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
DEC 15, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
FORTNER CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BAILEYSVILLE, W. VIRGINIA | | | |
| 24. FUNERAL DIRECTOR
W.W. CHAMBERS Co. RIVERDALE, MD. | | 25a. REC'D BY REGISTRAR
DEC 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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STATE OF TEXAS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 408 Maryland State Department of Health
1-15-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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| | | | | | | | | |
|--|------------------|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or Print) Larry Douglas Fowler | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 25 Year 1968 | | | 2b. HOUR 10:45 P.M. | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 6-5-13 | 6. AGE (In years last birthday) 55 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
Month 12 Day 25 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) Georgia | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Letter carrier | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First John Middle W. Last Fowler | | | 15. MOTHER'S MAIDEN NAME First Annie Middle Lou Last Hagerman | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | |
| 17. SOCIAL SECURITY NO. 254 18 1021 | | | 18. INFORMANT Mary B Fowler | | | 19. ADDRESS W Hyattsville, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive right subdural
DUE TO, OR AS A CONSEQUENCE OF
(b) hemorrhage and hematoma
DUE TO, OR AS A CONSEQUENCE OF
(c) lost | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
900.0 | | | | | | | | |
| 19a. DATE OF OPERATION 12/25/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 12/25 P.M. 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Deceased fell down basement stairs at home. | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | 21f. LOCATION Street or R.F.D. No. W. Hyattsville | | City or Town P.G. | | State Md. |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Reap M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED Dec. 26, 1968 | | |
| EXAMINER'S NAME (Type) BELDEN R. REAP M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (City, town, or county) Hyattsville, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Dec 30, 1968 | | 23c. NAME OF CEMETERY OR CREMATORIUM George Washington | | 23d. LOCATION (City or Town) (County) (State) Hyattsville Pro Geo Md. | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DEC 31 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17784 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17775 | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First
NELLIE | | | | | Middle
LOUISE | | | | | Last
FRAZIER | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | Month
DECEMBER | | | | | Day
2 | | | | | Year
68 | | | | | 7:45 PM | | | | | | | | | |
| 3. SEX
FEMALE | | | | | 4. RACE
CAUCASIAN | | | | | 5. DATE OF BIRTH
MARCH 31, 1934 | | | | | 6. AGE (In years
lost birthday)
34 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | | | IF UNDER 24 HRS.
HOURS MIN | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
TEXAS | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
NAVAL HOSPITAL | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
HOUSE WIFE | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
N/A | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
VIRGINIA | | | | | 13b. COUNTY
QUANTICO | | | | | 13c. CITY OR TOWN
QUANTICO | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
3502-B, MCB | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | First
NON | | | | | Middle
THOMAS | | | | | Last
VOUGHAN | | | | | 15. MOTHER'S MAIDEN NAME | | | | | First
BIRTIE | | | | | Middle
(UNKNOWN) | | | | | Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO | | | | | (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO.
463-48-9024 | | | | | 17. INFORMANT
Address
ROBERT R. FRAZIER, 3502-B, MCB, QUANTICO, VA. | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hodgkin's disease involving lungs and right ovary
201X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
201X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
YES | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from NOV. 23 , 19 68 , to DEC. 2 , 19 68 , that (X) (we) last
saw the deceased alive on DEC. 2 , 19 68 , and that in (X) (our) opinion death occurred on the date and hour and from the
causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John A. Routenberg MD | | | | | | | | | | | | | | | DEGREE
MD | | | | | | | | | | ATTENDING
PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
4 December 1968 | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
John A. Routenberg, M. D. | | | | | | | | | | | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | | | | 23b. DATE
12-7-68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Chapel Wood Mem. Park | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
ARLINGTON TEXAS | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
R.A. PUMPHREY FUNERAL HOME, 7557 WISCONSIN AVE. | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DEC 9 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 177765 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 177776 | | | | |
|---|---------|--|--|------------------------------------|-----------------|---|--|------------|---|--|----------|------------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | 2b. HOUR | | | |
| Andrew Vansice-French | | | | | | DEC 3 1968 | | | 9:15 | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS | 2c. DATE PRONOUNCED DEAD | | | Month Day Year | | 2d. HOUR | | | |
| M. | W. | April 14 1917 | 51 YRS. | MONTHS | DAYS | Dec - 3 | | | 1968 | | 9:30 | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. COUNTY OF DEATH | | | | | | | | |
| New Jersey | | U.S.A. | | WIDOWED | | Montgomery | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Rockville | | | 1617 Grunther Ave | | | Engineer | | | Gov. | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | |
| Md. | | | Montgomery | | | Rockville | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1617 Grunther Ave | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | |
| Andrew Vansice French | | | Mella Holland | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> WWII | | | 079-09-9273 | | | Wife - Mary Jane French - same item #13 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Maceration of Brain</u> | | | | | | | | | | Sudden | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gun shot wound of Head</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| 976X | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | |
| 9:15 P.M. | | | 12-3 1968 | | | Shot self in head 45 cal. Pistol | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | | |
| Home | | Home | | 1617 Grunther Ave | | Rockville | | Montgomery | | MD | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | | | | |
| John G. Ball | | | 7936 Old Georgetown Road | | | Dec 3, 1968 | | | | | | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER | | | DEPUTY MEDICAL EXAMINER | | | | | | | | |
| John G. Ball | | | Bethesda, Maryland | | | ADDRESS (Street, city, town, or county) | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | | |
| Burial | | 12/6/68 | | Winchester National | | Winchester, Virginia | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Tyson Wheeler | | | 1331 Rockville Pike | | | DA 0666 | | | 12/6/68 | | | | | |
| | | | Rockville, Maryland | | | | | | | | | | | |

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STATE OF NEW YORK

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IN SENATE

January 1, 1911

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

APRIL 1, 1910

1911

ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1911.

PRINTED BY THE STATE OF NEW YORK, 1911.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 17786 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 17777 | |
|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME
(Type or print) ELEANOR | | First FRISCH Last | | 2a. DATE OF DEATH
Month Dec Day 14 Year 1968 2b. HOUR 4:00 PM | |
| 3. SEX
female | | 4. RACE
White | | 5. DATE OF BIRTH
June 6, 1923 | |
| 7a. BIRTHPLACE (State or foreign country)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
12,001 Viers Mill Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spring | |
| 14. FATHER'S NAME
Maurice Kramer | | 15. MOTHER'S MAIDEN NAME
Mamie | | 16. SOCIAL SECURITY NO.
158-20-9139 | |
| 17. INFORMANT
Mr. Edward Frisch | | 18. ADDRESS
12,001 Viers Mill Rd. S.S. Md. | | 19. DATE OF OPERATION
12-16-68 | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | 22a. I certify that (I) (this hospital) attended the deceased from 8/19 , 19 68 , to 12/14 , 19 68 , that (I) (we) last saw the deceased alive on 12/13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
| 22b. SIGNATURE
David Goldenberg | | 22c. DATE SIGNED
12/14/68 | | 22d. PHYSICIAN'S NAME (Type)
DAVID GOLDENBERG | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-16-68 | | 23c. NAME OF CEMETERY OR CREMATORY
King Solomon Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Clifton N.J. | | 24. FUNERAL DIRECTOR
M. Andrew Duwall | | 25a. REC'D BY REGISTRAR
Warner E. Pumphrey Inc. 8434 Ga. Avenue S.S. | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. DATE
DEC 19 1968 | | 25d. ADDRESS
12,001 GEONIA, SILVER SPRING, MARYLAND | |

55551

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17778 | | |
|---|--|-----------------------------|--|--|--|--|--|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) <u>Francis</u> | | | First <u>Francis</u> Middle <u>Galen</u> Last <u>Galen</u> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>12</u> Day <u>25</u> Year <u>1968</u> | | | 2b. HOUR <u>5:20</u> M <u>PM</u> | | | |
| 3. SEX <u>male</u> | | 4. RACE <u>white</u> | | 5. DATE OF BIRTH <u>3-13-07</u> | | 6. AGE (In years last birthday) <u>61</u> YRS. | | IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> | | IF UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u> | | |
| 7a. BIRTHPLACE (State or foreign country) <u>Mass.</u> | | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH <u>Takoma Park</u> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>San & Hosp</u> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Engineer</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Navy Dept.</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>D.</u> | | | | 13b. COUNTY <u>Montgomery</u> | | | | 13c. CITY OR TOWN <u>Silver Spring</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First <u>John</u> Middle <u>B.</u> Last <u>Galen</u> | | | | 15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>--</u> Last <u>Johnson</u> | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If active war or dates of service) <u>WW II</u> | | | | |
| 16b. SOCIAL SECURITY NO. <u>577-60-3808</u> | | | | 17. INFORMANT <u>Gertrude Galen</u> | | | | ADDRESS <u>11200 Lockwood Dr. S.S., Md.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Coronary Artery Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year <u>19</u> HOUR A.M. <u>PM</u> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Golden R. Reap</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>Dec. 25, 1968</u> | | | | |
| EXAMINER'S NAME (Type) <u>BELOEN R. REAP M.D.</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>12-30-1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> | | | | |
| 24. FUNERAL DIRECTOR <u>J.W. Lee</u> | | | | ADDRESS <u>Sil. Spr., Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE | | |
| Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | DATE <u>JAN 3 1969</u> | | | | | | | | |

14778

WEEKLY LABOR REPORT OF DEPT.

FOR THE
MONTH OF

1968

01-01-1968

1968 JAN 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| 17768 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | CERTIFICATE OF DEATH | | 17779 | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>William</i> First <i>Kenneth</i> Middle <i>LXXX</i> Last <i>Gallagher</i> | | | 2a. DATE OF DEATH
Month <i>Dec</i> Day <i>18</i> Year <i>1968</i> | | | 2b. HOUR
<i>8 A.M.</i> | |
| 3. SEX
<i>male</i> | | 4. RACE
<i>W hite</i> | | 5. DATE OF BIRTH
<i>8/16/11</i> | | 6. AGE (In years last birthday)
<i>57</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Much</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S A</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Beltzede</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Dist mgn. Business</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md</i> | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Cherry Chase</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First <i>William</i> Middle <i>J</i> Last <i>Gallagher</i> | | 15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>Mc Dougall</i> Last <i>above</i> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
<i>No</i> | | 17. INFORMANT Address
<i>Wife Doris Gallagher</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<i>1890</i> IMMEDIATE CAUSE (a) <i>Adenocarcinoma, right kidney with diffuse wide-spread metastases</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>8 months</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>180X</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>1966</i> , to <i>Dec 18, 1968</i> , that (I) (we) saw the deceased alive on <i>Dec 18, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>James W. Egan MD</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
<i>James W. Egan</i> | | 22e. ADDRESS
<i>5413 Cedar Lane, Bethesda, Maryland</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<i>Burial</i> | | 23b. DATE
<i>Dec. 20, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Holy Cross Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Alpena, Michigan</i> | |
| 24a. FUNERAL DIRECTOR
<i>Garner & Pumphrey, Inc.</i> | | ADDRESS
<i>8434 Georgia Avenue</i> | | 25a. REC'D BY REGISTRAR
<i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |
| 24b. SIGNATURE
<i>C. Glen Carter</i> | | ADDRESS
<i>Silver Spring, Md.</i> | | DATE
<i>DEC 23 1968</i> | | | |

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UNITED STATES DEPARTMENT OF THE INTERIOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 151
30M REV 1-68

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|-----------------------------------|---|--|
| 1. DECEASED-NAME
(Type or print) CATHERINE | | First | | Middle | | Last GALLO | | 2a. DATE OF DEATH
Month 12 Day 4 Year 1968 | | 2b. HOUR
2A M | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
9-23-1921 | | 6. AGE (In years last birthday)
47 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
PATERSON N.J. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVERSPRING MD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOME | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
AW | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. COUNTY
MON 19. | | 13c. CITY OR TOWN
SILVERSPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
9904 COLESVILLE RD. | | | |
| 14. FATHER'S NAME
THOMAS DE FEE | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME
SARA BARBERA | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
UNKNOWN | | 17. INFORMANT
LOUIS GALLO, 13a, b, c, d above | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1541 TOXEMIA
DUE TO, OR AS A CONSEQUENCE OF
(b) CARCINOMA RECTUM METASTATIC
DUE TO, OR AS A CONSEQUENCE OF
(c) 6 mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 mo | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
154X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John O. Robben MD | | DEGREE | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
11-4-1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
John O. Robben MD | | 22e. ADDRESS
10400 CONNETT TAVENKENSINGTON MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
6 DEC. 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION (City or Town) (County) (State)
SILVER SPRING MD. | | | | | |
| 24. FUNERAL DIRECTOR
RINALDI FUNERAL HOME INC | | ADDRESS
740 GEORGIA AVE. NW | | 25a. REC'D BY REGISTRAR
DEC 6 1968 | | 25b. REGISTRAR'S SIGNATURE
John O. Robben | | | | | |

1438H

DEC 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17770 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17781 | | | | | | | | | |
|---|--|--|------------------------------|--|--|--|--|--|---------------------------------|--|--|-----------------------------|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH Month Day Year | | | | | | | | | | 2b. HOUR P. M. | | | | | | | | | |
| GALLOWAY ANN JOHNSTON GALLOWAY | | | | | | | | | | December 21 1968 | | | | | | | | | | 1:15 P. M. | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | | | | | | |
| Female | | | Caucasian | | | 10/14/81 | | | 87 YRS. | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Aberdeen, Scotland | | | U.S.A. | | | | | | Montgomery Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Silver Spring, Maryland | | | | | Colonial Village Nursing Home | | | | | Housewife | | | | | own home | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| 2009 Maryland | | | | | PRINCE GEORGE | | | | | Aurora | | | | | YES | | | | | 2009 Haysden Road | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| Thomas -- Johnston | | | | | Ann -- Dunbar | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| no -- | | | | | 0673 577-64-XXXX | | | | | Mrs. James A. Crawford 2009 Haysden Road | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Terminal hypostatic pneumonia | | | | | | | | | | | | | | | 8 days | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) A.S.H.D. & generalized debility | | | | | | | | | | | | | | | 6 months | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4200 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1967, to 12/21, 1968, that (I) (we) last saw the deceased alive on 12/20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| Hugh Grey, M.D. | | | | | | | | | | 11161 New Hampshire Avenue, Sil. Spr. Md. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 12-23-1968 | | | | | Cedar Hill Cemetery | | | | | Prince Georges, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| J.W. Lee Jr. Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | | | | | | DA DEC 26 1968 | | | | | | | | | | Charles Judge | | | | | | | | | |

11781

STATE OF TEXAS



DEC 8 1908

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17772

**MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17783

| | | | | | | | | |
|--|----------------------|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or Print) <i>Margaret Elizabeth Calkenson</i> | | | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> <i>Jan 51</i> 19 <i>68</i> <i>58</i> M | | | 2b. HOUR <i>5:30</i> M | | |
| 3. SEX <i>female</i> | 4. RACE <i>white</i> | 5. DATE OF BIRTH <i>9/19/20</i> | 6. AGE (in years last birthday) <i>48</i> YRS. | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | IF UNDER 24 HRS.
HOURS <i></i> MIN. <i></i> | 2c. DATE PRONOUNCED DEAD
Month <i>Jan</i> Day <i>31</i> Year <i>1968</i> <i>53</i> M | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Rhode Island U.S.A.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Rockville</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Electrician</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Electrician</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY <i>Mont.</i> | | 13c. CITY OR TOWN <i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First <i>Cornelius</i> Middle <i>McGuire</i> Last <i>McGuire</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Florence</i> Middle <i>Keough</i> Last <i>Keough</i> | | | 16. SOCIAL SECURITY NO. <i>039-10-9298</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | | 17. INFORMANT <i>Cornelius McGuire Central</i> | | | ADDRESS <i>281-Capitol St.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Multiple Injuries. Severe -</i>
<i>814.7</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Trauma from Impact of Auto.</i>
(b) <i>Trauma from Impact of Auto.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Sudden.</i> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>8124</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year <i>4:45 P.M. Dec 31 1968</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Stepped in front of Auto</i> | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i> | | | 21f. LOCATION Street or R.F.D. No. <i>Corner Twinbrook Pk. & Halpine Rd.</i> City or Town <i>Rockville</i> County <i>Montgomery</i> State <i>Md.</i> | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <i>Dec 31 1968.</i> | | |
| EXAMINER'S NAME (Type) <i>John G. Ball</i> | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| ADDRESS (Street, city, town, or county) <i>1331 Rockville Pike</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, <i>Burial</i> | | | 23b. DATE <i>1/6/1969</i> | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. St. Mary's Cemetery</i> | | |
| 24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home Rockville, Md.</i> | | | 23d. LOCATION (City or Town) <i>Pawtucket</i> | | | (County) <i>R. I.</i> | | |
| 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | DATE <i>JAN 6 1969</i> | | |

17783

RECEIVED

John C. Hall

Mr. T. J. Hall, 1000
Rockville Pike
Rockville, Md.
Tyson Hotel, General Home Rockville, Md.
JAN 10 1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 17782 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17782 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Item 7 Film G408 1/9/69 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last TESSIE GEVINSON | | | | | | | | | | 2a. DATE OF DEATH Month Day Year 12 31 68 | | | | | | | | | | 2b. HOUR 6:30 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX F | | | | | | | | | | 4. RACE WHITE | | | | | | | | | | 5. DATE OF BIRTH 5/30/99 | | | | | | | | | | 6. AGE (In years last birthday) 69 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) POLAND | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH MONTGOMERY Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) UNEMPLOYED | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C. | | | | | | | | | | 13b. COUNTY MONTGOMERY | | | | | | | | | | 13c. CITY OR TOWN D.C. WASHINGTON | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 1125 SPRING RD. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last BENJAMIN WITT | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last DEENA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT Harry Witt 75W Maple Ave H.K. PK. Md. | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4129 ACUTE BRONCHO PNEUMONIA. D.X. 15 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE WKS. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE YRS. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/22, 1968, to 12/31, 1968, that (I) (we) last saw the deceased alive on 12/31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE A. Albert H. Grollman | | | | | | | | | | 22c. DATE SIGNED 12/31/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) ALBERT H. GROLLMAN | | | | | | | | | | 22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 1-2-69 | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY OHEV SHOLOM TANUD TORAH | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Bernard Dancusky & Sons 3501-14th St N.W. Wash. D.C. | | | | | | | | | | 25a. REC'D BY REGISTRAR JAN 6 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

17782

CHRONOLOGICAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|--|--|---|--|-----------------------------|--|
| 17773 | | | | | | | | | |
| 17784 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR | |
| CARRIE - Gonder | | | | | 12 13 68 | | | 4 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | 2-20-2 | | 66 YRS. | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Ohio | | U. S. A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Springs | | Holy Cross Hospital | | NURSE | | NURSING | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Pa. | | Phila. | | Phila. | | | | 1522 Brown Street | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Amos Burkey | | | Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| | | | 199-01-1865B | | | Gregory Gonder, 1522 Brown St., Phila. Pa. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia + pleural effusion | | | | | | | | | |
| 433.9 DUE TO, OR AS A CONSEQUENCE OF (b) Paralysis of pharyngeal muscles | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Cerebral thrombosis | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 332 x | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 13, 1968, to Dec 13, 1968, that (I) (we) last saw the deceased alive on Dec 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Sydney Leventhal M.D. | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12/13/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| Sydney Leventhal | | | | 9210 Colesville Rd., S. S. Rd. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 12/16/68 | | Wooster Cemetery | | Wooster, Ohio | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Joseph Gawler's Sons, 5130 Wis. Ave. N.W. Washington D. C. 20016 | | | | DEC 19 1968 | | Charles Judge | | | |

13784

RECORD OF DEATH

1902 Brown Street

X

CHINA

CHINA

PA.

Unknown

Unknown

AMOS

1902-1882 Brown Street, 1902 Brown St., China, Pa.

10

1910 Columbia St., S. E. Rd.

1910 Columbia St.

1910, 1910

1910, 1910

1910, 1910

1910, 1910

1910, 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17774

17785

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Peter</i> | | | First Middle Last | | | 2a. DATE OF DEATH
Month <i>12</i> Day <i>24</i> Year <i>1968</i> | | | 2b. HOUR
<i>10 a</i> M | | |
| 3. SEX
<i>MALE</i> | | | 4. RACE
<i>White</i> | | | 5. DATE OF BIRTH
<i>17 June 1891</i> | | | 6. AGE (In years last birthday)
<i>77</i> YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>GREECE</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)
<i>RESTAURANTER</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MARYLAND</i> | | | 13b. COUNTY
<i>MONTGOMERY</i> | | | 13c. CITY OR TOWN
<i>Rockville</i> | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
<i>1424 KRIERWOOD TERR.</i> | | | 14. FATHER'S NAME First Middle Last
<i>JOHN - GOUNARIS</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>PACHINE - UNK</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
<i>092-01-9640</i> | | | 17. INFORMANT
<i>HELEN - GOUNARIS</i> | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
<i>Coronary Artery Disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Pneumonic Lung Disease, Chronic</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Parkinson's Disease</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>One Hour</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<i>4201</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-15-</i> , 19 <i>68</i> , to <i>12-24-</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-24</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>George T Economos</i> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>12-24-68</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>George T Economos</i> | | | | | | 22e. ADDRESS
<i>2141 K. St. N.W. Wash D. C.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
<i>26 Dec 1968</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>PARKLAWN CEMETERY</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Rockville MD.</i> | | |
| 24. FUNERAL DIRECTOR
<i>RINALDI FUNERAL HOME, Inc.</i> | | | | | | ADDRESS
<i>7406 GEORGIA AVE, NW</i> | | | 25a. REC'D BY REGISTRAR
<i>Charles Judge</i> | | |
| | | | | | | DATE
<i>DEC 27 1968</i> | | | 25b. REGISTRAR'S SIGNATURE | | |

48751

1950 10 10

000 1 8 330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 | | | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|---|--|-------------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Joseph Anthony R. Grand | | | | | | 2a. DATE OF DEATH
Dec Month 7 Day 1968 Year | | | 2b. HOUR
1:15 M | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
6-8-1940 | | | 6. AGE (In years last birthday)
28 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Wash DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Teacher | | | 12b. KIND OF BUSINESS OR INDUSTRY
Mt. Co. Schol | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spr. Md. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
310 Brewster Ct. | | |
| 14. FATHER'S NAME First Middle Last
Joseph A Grand | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Eileen -- Bowman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | | | 16b. SOCIAL SECURITY NO.
Yes | | 17. INFORMANT
Robert Grand | | Address
310 Brewster Ct. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis
428X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Several Months | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4222 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept , 1968, to Dec 7 , 1968, that (I) (we) last saw the deceased alive on Dec 6 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert P. Montgomery, MD | | | | | | 22c. DATE SIGNED
Dec 7, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT P. MONTGOMERY | | | | | | 22e. ADDRESS
5411 CEDAR LANE BETHESDA, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-10-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | | | |
| 24. FUNERAL DIRECTOR
Lee Warner E. Pumphrey, Inc. | | | | ADDRESS
Sil. Spr. Md. | | | | 25a. REC'D BY REGISTRAR
DEC 12 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

11188

RECEIVED OF DEATH

Robert G. ...

Robert G. ...

Washington, D. C.

U. S. Census Bureau

12-10-1988

Form

DEC 15 1988

U. S. Census Bureau

U. S. Census Bureau

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17787 | |
|--|--|------------------|---|--|---|--|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) Willard Woodrow Grant | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 6 Year 1968 | | 2b. HOUR 10:20 A.M. | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH Nov-09-21 | | 6. AGE (In years last birthday) 47 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) US - VA. | | | 7b. CITIZEN OF WHAT COUNTRY? US | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Mont. Co | | Md. | |
| 10. CITY OR TOWN OF DEATH Takoma Park, Md. | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dr. CHIROPRACTIC | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | 13b. COUNTY US MONT | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 12109 New Hampshire Ave. | |
| 14. FATHER'S NAME First Julian Middle Garnet Last Grant | | | | | | 15. MOTHER'S MAIDEN NAME First Virginia Middle Washington Last ? | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16b. SOCIAL SECURITY NO. 225 12 5073 | | 17. INFORMANT ADDRESS MRS. MARY ALICE GRANT (SAME) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7824 Acute cardiorespiratory failure,
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. cause undetermined
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
7824 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Yeapher | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED Dec. 6, 1968 | | | |
| EXAMINER'S NAME (Type) BELDEN R. YEAPHER | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS Street City Town, or County | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Dec. 10, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Date of Heaven Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Montgomery Co. Md. | | | |
| 24. FUNERAL DIRECTOR Takoma Funeral Home, J. Arthur Waller, 254 Carroll St NW | | | | | | 25a. REC'D BY REGISTRAR J. Charles Judge | | 25b. REGISTRAR'S SIGNATURE | | | |
| DATE DEC 9 1968 | | | | | | | | | | | |

11787

11787

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|----------------------------------|--|--|--|---|---|--|-----------------------------|--|--|----------------------------|--|--|-------|--|-------|--|
| 17777 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17788 | |
| Item 13 Film 408 1/17/69 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | |
| CLAIRE | | | | | M | | | | | GRAY | | | | | DECEMBER 15 1968 6:30 AM | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | | | | |
| Female | | | White | | | April 20, 1896 | | | 72 YRS. | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | |
| France | | | USA | | | | | | Montgomery Md. | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| Keensington | | | Canoe Manor | | | Retired | | | Teacher | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Md | | | V.P.G. 114411 | | | 114441X | | | | | | 10300 Livingston Rd. | | | | | | | | | |
| 14. FATHER'S NAME | | | | | First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME | | | | | First Middle Last | | | | | | |
| Emile | | | | | Gullman | | | | | Claire | | | | | Pajaro | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | | | | | |
| no | | | no | | | — | | | Suzanne Roux 10300 Livingston Rd Swarthmore Pa | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC MYOCARDITIS | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| (c) GENERALIZED ARTERIOSCLEROSIS | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | |
| 4221 SENILITY | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| | | | HOUR A.M. Month Day Year 19 P.M. | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | Street or R.F.D. No. | | | City or Town | | | County | | | State | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEP 30, 1968, to DEC 15, 1968, that (I) (we) last saw the deceased alive on DEC 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | |
| Henry J. Funder MD DEGREE | | | | | 12/15/68 | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | |
| | | | | | 5306 Norway Dr. Chevy Chase, Md. | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | |
| Burial | | | 12-17-68 | | | St. Marys Church Cem | | | Piscataway Md. | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| Robert E. Wickholm | | | | | 4308 Suitland Rd Suitland Md | | | | | DEC 24 1968 | | | J. Charles Judge | | | | | | | | |

11758

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11758

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|--------------------------|--|--|---|--|--|---------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
EDITH | | | Middle
M | | | Last
GRAY | | | 2a. DATE OF DEATH
Month
DECEMBER | | | Day
24 | | | Year
1968 | | | 2b. HOUR
5 ²³ P M | | |
| 3. SEX
7 | | | 4. RACE
W | | | 5. DATE OF BIRTH
Oct. 2 - 1895 | | | 6. AGE (In years
lost birthday)
73 YRS. | | | IF UNDER 1 YEAR
MONTHS | | | IF UNDER 24 HRS.
DAYS | | | HOURS | | | MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
KENSINGTON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
CARROLL HALL SAN | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
DRY CLEANING | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Jewelry | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | | 13b. COUNTY
Prince Georges | | | 13c. CITY OR TOWN
Capitol Hill | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
5810 Walker Mill Rd. | | | | | | | | | | | |
| 14. FATHER'S NAME
John | | | First
H | | | Middle
BAYNE | | | 15a. MOTHER'S MAIDEN NAME
MARY | | | First
ELLEN | | | Middle
DACEY | | | Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
No | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
579-28-2346 A | | | 17. INFORMANT
Address
Sister as
Sister as
13E | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> | | | | | | | | | | | | | | | | | | 72 HOURS | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | |
| 4200 <u>SENILITY</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-30</u> , 1968, to <u>12-24</u> , 1968, that (I) (we) last saw the deceased alive on <u>DEC. 24</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Henry J. Snowden</u> | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/24/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
HENRY J. SNOWDEN | | | 22e. ADDRESS
529 E. Navyway Dr.
Chesapeake, Md. | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE
12-28-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
EPIPHANY CEMETERY | | | 23d. LOCATION (City or Town)
FORESTVILLE | | | (County) | | | (State)
MD | | | | | | | | |
| 24. FUNERAL DIRECTOR
W.W. Chambers Co | | | ADDRESS
517-11th St SE | | | 25a. REC'D BY REGISTRAR
DEC 31 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|---|---|---|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
DONNA J. GREEN | | | | | 2a. DATE OF DEATH Month Day Year
DEC 22 1968 | | 2b. HOUR
3:00A | | |
| 3. SEX
FEMALE | | 4. RACE
CAUC | | 5. DATE OF BIRTH
1 MAY 1929 | | 6. AGE (In years last birthday)
40 39 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
WYOMING | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
CHARLES | | 13c. CITY OR TOWN
INDIAN HEAD | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
RT 1, BOX 61 | |
| 14. FATHER'S NAME First Middle Last
RUDOLPH D. ZABLOUDIL | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ALICE SUCHANEK | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)
NO | | 16b. SOCIAL SECURITY NO.
216-38-5920 | | 17. INFORMANT Address
JOSEPH C. GREEN SAME | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
180X IMMEDIATE CAUSE (a) Septicemia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of the Cervix
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
171X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from 26 NOV , 19 68 , to 22 DEC , 19 68 , that he (we) last saw the deceased alive on 22 DEC , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Joseph L. Yon</i> | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
22 December 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
J. L. YON, LCDR MC USN | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-26-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Arlington Va. | | | |
| 24. FUNERAL DIRECTOR
Arehart Funeral Home, Inc.
LaPlata, Maryland | | | | 25a. REC'D BY REGISTRAR
DEC 27 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | | | |

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| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|-----------------------------------|--|--|-------|--|
| 17780 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 17791 | |
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | 2a. DATE OF DEATH Month Day Year | | | | 2b. HOUR | | | |
| ARTHUR Griffith | | | | | | 12 7 68 | | | | 3 45 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| MALE | | CAUC. | | 11-3-93 | | 75 YRS. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Penn. | | USA | | | | Montgomery County | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Silver Spring | | | 1000 Oakview Ave. ALHAWOOD LAND | | | Drv. EEC | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MD. | | | MONTGOMERY | | | Silver Spring | | YES | | 405 Greenview Dr. | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | |
| John T Griffin | | | Gertrude BROWN | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | | | |
| Unknown | | | 216-44-2772 | | | Leah Robinson RN 2325-15th St. N.W. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Metastatic anaplastic carcinoma | | | | | | | | | | 6 mos. | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) — | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) — | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 1992 — | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 1968 | | As above | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1967, 19, to Dec 7, 1968, that (I) (we) last saw the deceased alive on Dec 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Bennet A. Porter, Jr., M.D. DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED December 7, 1968 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D. | | | | 22e. ADDRESS 9301 Colesville Rd, Silver Spring, Md. | | | | | | | | | |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| | | 12-10-68 | | FT. LINCOLN | | COLEMAN MANOR MD | | | | | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co. ADDRESS WASH. D.C. | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| W.W. CHAMBERS Co. 1400 CHAPIN ST. N.W. | | | | DEC 12 1968 | | J. Charles Judge | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 17781 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17792 | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| Item 23 Film 408 1/7/69 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | First John Middle Kimberly Last Griggs | | | | | 2a. DATE OF DEATH | | | | | Month December Day 23 Year 1968 | | | | | 2b. HOUR 4:23 PM | | | | | | | | | |
| 3. SEX Male | | | | | 4. RACE White | | | | | 5. DATE OF BIRTH 26 November 1957 | | | | | 6. AGE (In years last birthday) 11 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Georgia | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH Montgomery Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) student | | | | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | 13b. COUNTY Montgomery | | | | | 13c. CITY OR TOWN Takoma Park | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER 704 Gilbert Street | | | | | | | | | |
| 14. FATHER'S NAME First James C. Middle Griggs Last | | | | | 15. MOTHER'S MAIDEN NAME First Laura Middle Chalker Last | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | | | | 16b. SOCIAL SECURITY NO. None | | | | | 17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Septic shock | | | | | | | | | | | | | | | 15 minutes | | | | | | | | | | | | | | |
| 2040 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Systemic candidiasis | | | | | | | | | | | | | | | 2 weeks | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) Acute lymphocytic leukemia | | | | | | | | | | | | | | | 2 years | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2043 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Nov. 30, 1968, to Dec. 23, 1968, that (X) (we) last saw the deceased alive on December 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>DH Riddick, MD</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED December 23, 1968 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) David H. Riddick, M.D. | | | | | | | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, Burial | | | | | 23b. DATE 12/24/68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Forest Hill | | | | | 23d. LOCATION (City or Town) Eastpoint, (County) Ga. (State) | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler F.H. 1331 Rockville Pk. Rockville, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 27 1968 | | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1968

| 17782 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 17793 | |
|--|--|--|--|--|--|
| Mamie Ager Grosch | | | | | |
| 1. DECEASED-NAME (Type or print) | | First Middle Last | | 2a. DATE OF DEATH | |
| MAMIE AGER | | Grosch | | Month Day Year | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Female | | White | | 10/18/189 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (In years last birthday) | |
| Phila. Pa | | USA | | 79 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Bethesda | | Suburban Hospital | | 9. COUNTY OF DEATH | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY OR TOWN | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| Maryland | | Montgomery Silver Spring | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 9. COUNTY OF DEATH | |
| First Middle Last | | First Middle Last | | Montgomery | |
| Walter F. Anthony | | Katherine L. McMahon | | Md | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 770-1 579-31 5355A | | Katherine M. Barnes, Daughter | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary Infarction | | sev. min | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | sev. days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) Inactivity of illness | | many years | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (c) Congestive Heart Failure & Arteriosclerotic Disease | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 4200 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1963, to Dec 22, 1968, that (I) (we) - last saw the deceased alive on Dec 21 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| George H. Mitchell M.D. | | 12/22/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| George H. Mitchell | | 11125 Rockville Pike, Rockville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 12-26-1968 | | Gate of Heaven Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) | | 23e. REC'D BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Silver Spring, Montgomery Co. Md. | | DEC 27 1968 | | J Charles Judge | |
| 24. FUNERAL DIRECTOR | | 24a. Ave. N.W., Wash., D.C., 20016 | | 24b. DATE | |
| Joseph Gawler's Sons, Inc. | | | | DEC 27 1968 | |

MEDICAL CERTIFICATION

11788



01031 1988

11788 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLERKED WITH MEDICAL EXAMINER 12-26-68

17783

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17794

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|-------------------------------------|--|
| 1. DECEASED-NAME
(Type or print) Paul First Middle M. Last Grubb | | | 2a. DATE OF DEATH
Month 12 Day 21 Year 68 | | | 2b. HOUR
10:20 M | | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
5/14/05 | | 6. AGE (In years
lost birthday)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Tennessee | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spg. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Wheaton Plaza Theatre, Mgr. | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MD | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spg. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8708 First Ave. | | | |
| 14. FATHER'S NAME
First James Middle Frank Last Grubb | | | 15. MOTHER'S MAIDEN NAME
First Lulu Middle -- Last Nunn | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes, give war or dates of service)
WW II | | 16b. SOCIAL SECURITY NO.
413-09-6150 | | 17. INFORMANT
Mrs. Lenore Grubb | | Address Sil. Spg., Md.
8708 First Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4339 IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS APPROXIMATE INTERVAL
DUE TO, OR AS A CONSEQUENCE OF 32 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE DUE TO, OR AS A CONSEQUENCE OF 2-3 yrs
332X (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
DIABETES MELLITUS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-19, 1968 to DEC 21, 1968 , that (I) (we) last saw the deceased alive on 12/20/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harold S. ... | | DEGREE
MD | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/21/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Harold S. ... | | 22e. ADDRESS
13584 W. ... | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-26-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Grandview Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Freeport Stephenson, Ill. | | | | | |
| 24. FUNERAL DIRECTOR
C. Glen Carter | | ADDRESS
Sil. Spg. Md. | | 25a. REC'D BY REGISTRAR
DEC 26 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | |
| 26. FUNERAL HOME
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | | | | | | | |

11104

RECEIVED



11104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) EDWARD MORRIS HAAS | | 20. DATE OF DEATH
12 Month 16 Day 68 Year | | 2b. HOUR
5¹⁵ P M | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
6/3/80 | |
| 70. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON SAN. & HOSP. | | 120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
ENGRAVER | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | |
| 14. FATHER'S NAME
? (Unknown) | | 15. MOTHER'S MAIDEN NAME
? (Unknown) | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO.
220-44-7885 | | 17. INFORMANT
Heleh Anderson | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4319
IMMEDIATE CAUSE (a) Cerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerosis - generalized
DUE TO, OR AS A CONSEQUENCE OF
(c) | | 13e. STREET AND NUMBER
8811 Cdesville Rd. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 hours
5 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
331X | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 220. I certify that (I) (this hospital) attended the deceased from Mar 1967 , to Dec 10, 1968 , that (I) (we) last saw the deceased alive on Dec 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
HARRY N. CARLTON, MD | | 22c. DATE SIGNED
Dec 10, 1968 | | 22d. PHYSICIAN'S NAME (Type)
HARRY N. CARLTON | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
Buried | | 23b. DATE
12-13-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Lincoln Cemetery | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 24a. REC'D BY REGISTRAR
DEC 16 1968 | | 24b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

1751

1752

CENTRAL INLAND

6

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

DEC 1 1960
UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 410 Maryland State Department of Health
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17796

| | | | | | | | | | | | | | |
|--|---------|------------------|--|--------------------------------|--|---|--|--|--|---|------------|------------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input type="checkbox"/> Month Day Year | | | 2b. HOUR P | | | | |
| William Frederick HAHN | | | | | | Dec. 30 1968 | | | 4:05M | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | | 2d. HOUR P | | |
| Male | Cauc. | Oct. 2, 1946 | 22 YRS. | | | | | Dec. 30 1968 | | | 4:05M | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | |
| Missouri | | | USA | | | | | | Montgomery | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Bethesda | | | Naval Hospital | | | Student | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | |
| Maryland | | | Pr. George | | | College Park | | | | | | 7403 Hawkins Ave. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| William R. HAHN | | | Marian G. Kammerer | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Drive, Winter Park | | | ADDRESS Florida | |
| No | | | 265 90 3709 | | | CDR William R. Hahn, USN, Ret. | | | 2112 Fosgate | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Periodic paralysis, sporadic</u>
DUE TO, OR AS A CONSEQUENCE OF <u>type, Clinical</u>
(b) <u>Hypokalemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 hr. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>352x</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | | John G. Ball, M. D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | 22b. DATE SIGNED
31 December 1968 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | JAN 6, 1969 | | | DeLand Memorial Garden | | | DeLand, Volusia County Florida | | | | |
| 24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS
5801 Cleveland Ave. Riverdale, Maryland | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 14 1969 | | | 25b. REGISTRAR'S SIGNATURE | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|-------------------|---|--|--|---|---|---|---|--|--------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last
Burnell Hughes HAINES | | | 2a. DATE KNOWN OF DEATH
Month Day Year
DEC. 1 1968 | | 2b. HOUR
340A | | | |
| 3. SEX
MALE | 4. RACE
CAUCA. | 5. DATE OF BIRTH
FEB. 15, 1940 | 6. AGE (in years last birthday)
28 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year
Dec. 1 1968 | | | |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U. S. Navy | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
New Windsor | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Route 1 | | |
| 14. FATHER'S NAME
First Middle Last
Ralph Anthony Haines | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Bessie Katherine Hughes | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
Yes | | | 16b. SOCIAL SECURITY NO.
1958-68 213 38 7666 | | 17. INFORMANT
Navy Records | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries, severe
816.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Trauma from auto accident
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
8234 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
sudden | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 336 P.M. DEC. 1 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
loss control of car and hit a wall | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Highway | | 21f. LOCATION Street or R.F.D. No.
RT124, | | City or Town
Gaithersburg | | County
Montgomery | | State
MD. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
John G. Ball | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | 22b. DATE SIGNED
DEC. 3, 1968 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-5-68 | | 23c. NAME OF CEMETERY OR CREMATORY
St. James Methodist Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Dennings Md. | | | | |
| 24. FUNERAL DIRECTOR
W. W. Chambers Co.
1400 Chapin Street, N.W., Washington, D.C. | | | | 25a. REC'D BY REGISTRAR
DEC 9 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

THE STATE
OF NEW YORK

1932

OFFICE OF THE
COMMISSIONER OF LABOR

1932

| | | | | | |
|------------------------|--|-----------------------|--|---------------------------|--|
| Name of Employer | | Address of Employer | | City and State | |
| Name of Employee | | Address of Employee | | City and State | |
| Occupation of Employee | | Description of Work | | Date of Injury | |
| Cause of Injury | | Nature of Injury | | Result of Injury | |
| Treatment of Injury | | Medical Expenses | | Lost Wages | |
| Other Expenses | | Total Expenses | | Total Wages | |
| Signature of Employer | | Signature of Employee | | Signature of Commissioner | |
| Date of Filing | | Date of Payment | | Date of Settlement | |

CERTIFICATE OF DEATH

17798

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) George | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
1:20 PM | | |
| 3. SEX
Male | | | 4. RACE
Cauc. | | | 5. DATE OF BIRTH
June 28, 1895 | | | 6. AGE (In years last birthday)
73 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Potomac Valley Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Painter (Retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Rockville | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
208 Harrison Street | | | 14. FATHER'S NAME
First Middle Last
George Haines | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary (Unknown) | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
No | | |
| 16b. SOCIAL SECURITY NO.
214-12-7068 | | | 17. INFORMANT
Address
Lola G. Haines 208 Harrison St. Rockville, Md. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma (adeno)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 Months | | | 19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1992 Coronary artery disease | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1963 , to 12-27 , 19 68 , that (I) (we) last saw the deceased alive on 12-24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Donald L. Bucy | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type)
DONALD L. BUCY | | | | | | 22e. ADDRESS
809 Veirs Mill Rd. Rockville, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REPOUR (Type) | | | 23b. DATE
Dec. 30, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Oak Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Gaithersburg, Montgomery Md | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Robert A. Pumphrey, 7557 Wisconsin Ave. Bethesda, Md. | | | | | | 25a. REGISTERED
JAN 10 1969 | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

88778

UNITED STATES OF AMERICA

THE UNITED STATES OF AMERICA - DEPARTMENT OF THE ARMY - OFFICE OF THE ADJUTANT GENERAL

OFFICE OF THE ADJUTANT GENERAL

1945

UNITED STATES OF AMERICA

1945

1945

UNITED STATES OF AMERICA - DEPARTMENT OF THE ARMY - OFFICE OF THE ADJUTANT GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Send with Jones & Gomer

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--------------------------|--|---|--|--|--|--|
| 17788 | | | | | 17799 | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| MRS. Olive -- Halbruner | | | | | Month 12 Day 19 Year 68 | | | 3:00 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| F | | White | | 5-13-86 | | 82 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| New Jersey | | U.S.A. | | | | Montgomery | | own home | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Holy Cross Hosp. | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Montgomery | | Sil. Spr. | | | | 2605 Glenallen Avenue | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Joseph -- Joseph | | | (unknown) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | yes | | Franklin Halbruner | | Sil. Spr., Md. 2605 Glenallen Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) cerebrovascular accident | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) acute myocardial infarction | | | | | | | | 96 hr | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) coronary atherosclerosis | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4201 mm | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/19, 19 68, to 12/19, 19 68, that (I) (we) last saw the deceased alive on 12/19, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | |
| Lewis A. Dennis MD | | | | | 12/19/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| Lewis A. Dennis MD | | | | | 2906 Rd Pr Rd, Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 12-23-1968 | | Cold Spring Cemetery | | Cold Spring, New Jersey | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | DATE 12 23 1968 | | Charles J. Jones | | |

11738

RECORDS OF DEATH

11738

11738



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|----------------------|---|--|--|---|--|-------|---|--|--|
| 17720 | | CERTIFICATE OF DEATH | | | | | | 17800 | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
LOLA | | | Middle
MAY | | | Last
HALL | | |
| 2. DATE OF DEATH | | | Month
Dec. | | | Day
24 | | | Year
1968 | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
July 28, 1880 | | | 6. AGE (In years last birthday)
88 | | |
| 7a. BIRTHPLACE (State or foreign country)
Kansas | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Althea Woodland Nurs-
ing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Teacher | | | 12b. KIND OF BUSINESS OR INDUSTRY
Public Sch- | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, give admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Bethesda | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
6110 Bradley Blvd. | | | 14. FATHER'S NAME
First
Nathan | | | Middle
Davis | | | Last
Abigail | | |
| 15. MOTHER'S MAIDEN NAME
First
Newby | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
No | | | 16b. SOCIAL SECURITY NO.
216-46-0491 | | | 17. INFORMANT
6106 Bradley Blvd.
Mr. Robert McCormick, Bethesda, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
4339
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
Several years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
332x <u>None</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (we) attended the deceased from <u>1964</u> , 19 <u>64</u> , to <u>Dec 24, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>James W Egan M.D.</u> | | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
<u>Dec 25-1968</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
JAMES W. EGAN, M.D. | | | | | | 22e. ADDRESS
<u>5413 Cedar Lane - Bethesda, Md</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | 23b. DATE
12/26/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Pr. Geo. Md. | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | 25a. REC'D BY REGISTRAR
JAN 2 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

17800

LOLA

MAY

HALE

Female

White

July 23, 1880

33

Kansas

U.S.A.

Mont. Omerly

Silver Spring

White Woodland House

Public 20

Marshall

Marshall

White Woodland House

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Marshall 12/20/88 Cedar Hill Cemetery

Marshall 12/20/88 Cedar Hill Cemetery

Marshall 12/20/88 Cedar Hill Cemetery

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office, along with form PMS, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17790

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17801

| | | | | | | | |
|--|----------------------|---|---|---|--|--|--|
| 1. DECEASED-NAME (Type or Print) <i>Charles H Hallman</i> | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <i>1968</i> | | | 2b. HOUR <i>1:30</i> M | |
| 3. SEX <i>Male</i> | 4. RACE <i>Negro</i> | 5. DATE OF BIRTH <i>July 12, 1921</i> | 6. AGE (In years last birthday) <i>47</i> YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month <i>Dec.</i> Day <i>2</i> Year <i>1968</i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | |
| 10. CITY OR TOWN OF DEATH <i>Dickinson</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Route 2</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Truck Collector</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i> | | 13b. COUNTY <i>Mont</i> | | 13c. CITY OR TOWN <i>Dickinson</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First <i>John</i> Middle <i>H</i> Last <i>Hallman</i> | | 15. MOTHER'S MAIDEN NAME First <i>Florence</i> Middle <i>Only</i> Last <i>Only</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Thrombosis Acute.</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <i>Coronary Arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i>
<i>years.</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <i>19</i> P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>John S. Ball</i> | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>Dec 2, 1968</i> | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 23b. DATE <i>12-5-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion Ch. Cemetery Sellman Montg. Md.</i> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <i>Robert L. Snowden</i> | | ADDRESS <i>Rockville, Md.</i> | | 25a. REC'D BY REGISTRAR <i>DEC 5 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i> | |

17801

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

FOR FILE
FBI

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11-11-80 BY SP-10
JAN/81

100 330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17791 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17802 | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--------------------------------|--|--|-------------------------------|--------------------------|--|--|--|---------------|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH
Month Day Year | | | | | | | | | | 2b. HOUR
M | | | | | | | | | | | | |
| Kermit Elwood Hamilton | | | | | | | | | | 12 13 68 | | | | | | | | | | 1:58 | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN | | | | | | | | | | | | | | | | | |
| male | | | white | | | 8-9-33 | | | 35 YRS. | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| Virginia | | | United States | | | | | | Montgomery Co Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Takoma Park | | | Washington Sanitarium | | | | | | | | | | Electrician-unemployed | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | Prince George's | | | Adelphi | | | YES | | | 9302 Adelphi Rd Apt 103 | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | | | | | | | | |
| | | | | | | No | | | | | | | | | | 230 36 0184 | | | Blanche Hamilton
Washington Sanitarium Records Takoma Park Md | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hepatic Coma</u>
571.0 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>581.1</u>
(b) <u>Laennec's Cirrhosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>several years</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 wks</u> | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>Peptic Ulcer</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | | County | | | State | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/29</u> , 19 <u>68</u> , to <u>12/13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | |
| Israel Spector MD | | | 12/13/68 | | | Israel Spector | | | Silver Springs, Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | Dec 16, 1968 | | | Ft Lincoln Cemetery | | | Colmar Manor Pro Geo Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | |
| F. Gasch's Sons | | | Hyattsville, Md. | | | DEC 18 1968 | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | |

In the County of ...
 State of New York
 I, the undersigned, Clerk of the Court,
 do hereby certify that the within and
 foregoing is a true and correct copy
 of the original of the same as the same
 is on file in the office of the Clerk of the Court.
 In testimony whereof, I have hereunto set my hand
 and the seal of the Court at ...
 this ... day of ... 19...

Signed and sealed in presence of
 the undersigned, Clerk of the Court,
 at ...
 this ... day of ... 19...

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17792

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17803

| | | | | | | | | | |
|--|----------------------|--|--|---|--|--|---|-----------------------------------|--|
| 1. DECEASED-NAME
(Type or Print) Mabel C. HARLEY | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year Dec. 5 1968 | | | 2b. HOUR 4:25 M | | | |
| 3. SEX FEMALE | 4. RACE White | 5. DATE OF BIRTH 7/6/1911 | 6. AGE (In years last birthday) 57 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year Dec. 5 1968 | | | 2d. HOUR 4:25 AM |
| 7a. BIRTHPLACE (State or foreign country) Washington DC | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md | | | 13b. COUNTY Montgomery Bethesda | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5402 Christy Drive |
| 14. FATHER'S NAME First Middle Last Harry Coggins | | | 15. MOTHER'S MAIDEN NAME First Middle Last Ernestine Hammack | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS Drive | | | 17. INFORMANT ADDRESS Mrs. Calanthe H. Spencer -90220 Oceanwood | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetic Coma. with Acidosis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2500
(b) Diabetes Mellitus
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Hours?
years. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260X Emaciation - Metabolic Deficiency - | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE John S. Ball M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED Dec - 5, 1968. | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 12/9/68 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR ADDRESS The S.H. Hines Co. Washington, D. C. | | | | 25a. REC'D BY REGISTRAR DATE DEC 10 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

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Mr. [redacted] - [redacted]

050 01 030

The S. E. Miles Co., Keating, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17793 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17804 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last
Louise Theresa Harmuth | | | | | | | | | | 12 Month 18 Day 68 Year | | | | | | | | | | 10:30 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Female | | | | | | | | | | 4. RACE
Caus. | | | | | | | | | | 5. DATE OF BIRTH
8/13/1894 | | | | | | | | | | 6. AGE (In years last birthday)
74 YRS. | | | | | | | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Brooklyn, N.Y. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
University Nursing Home | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Machine operator | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | | | | | | | 13b. CITY OR TOWN
Montgomery | | | | | | | | | | 13c. INSIDE CITY LIMITS?
Silver Spring <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13d. STREET AND NUMBER
808 Horton Drive | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
George Aplustille | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
Theresa Schmidt | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | | | | | | | | | 16b. SOCIAL SECURITY NO.
121-20-1448 B | | | | | | | | | | 17. INFORMANT
WILLIAM HARMUTH | | | | | | | | | | Address
SAME AS #13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>203 X</u> <u>Coron. vascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Multiple myeloma</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>one day</u>
<u>one year</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>203 X</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 18</u> , 19 <u>67</u> , to <u>Dec 18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 18</u> , 19 <u>68</u> , and that in (my) (our) apian death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Edward Adelson M.D. | | | | | | | | | | 22c. DATE SIGNED
Dec. 18, 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS
1100 22nd ST N.W. Wash D.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | | | | | 23b. DATE
Dec. 20, 1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Geo. Washington | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Prince George Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
James Collins | | | | | | | | | | 25a. REC'D BY REGISTRAR
DEC 27 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17805

| | | | | | | | | | |
|--|----------------------|---|---|--|---|---|--|--|-----------------|
| 1. DECEASED-NAME
(Type or Print) Robert Cline Harris | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 12 16 1968 | | | 2b. HOUR 9:15 A.M. | | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH May 22, 1923 | 6. AGE (in years last birthday) 45 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month Dec Day 16 Year 1968 | | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Super Giant | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Annapolis Jct. | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER PO Box 47 | | |
| 14. FATHER'S NAME First William Middle Jennings Last Harris | | | 15. MOTHER'S MAIDEN NAME First Hazel Middle A. Last Calley | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) Army | | | 16b. SOCIAL SECURITY NO. 579-14 4684 | | 17. INFORMANT Ruth Harris / 52 me at above | | | ADDRESS (5157) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficiency Acute -
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cardio Vascular Disease.
(b) years.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 or 4 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. 19 | | City or Town 19 | | County 19 | State 19 |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE John S. Ball | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED - DEC 16, 1968 | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-19-68 | | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 23d. LOCATION (City or Town) Burtonville Md. | | (County) (State) | |
| 24. FUNERAL DIRECTOR Canadian Funeral Home Laury | | | ADDRESS | | | 25. REC'D BY REGISTRAR DEC 23 1968 | | 25b. REGISTRAR'S SIGNATURE | |

13302

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

TO: DIRECTOR

FROM: SAC, NEW YORK



| | |
|----------------|-----------------|
| DATE | 12/12/60 |
| TO | DIRECTOR |
| FROM | SAC, NEW YORK |
| SUBJECT | RE: [Illegible] |
| REFERENCE | [Illegible] |
| SYNOPSIS | [Illegible] |
| DETAILS | [Illegible] |
| CONCLUSION | [Illegible] |
| RECOMMENDATION | [Illegible] |
| ADMINISTRATIVE | [Illegible] |
| OTHER | [Illegible] |

DEC 13 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|--------------------------|---|---|-----------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 17806 | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Glen Vernon Harrison | | | | | | December 18 1968 | | 11 P 45 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Male | | White | | August 30th 1968 | | YRS. MONTHS DAYS | | 3 10 | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Wash, D.C. | | U.S.A. | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | | | Holy Cross | | | None | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | Bladensburg | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5209 Newton Street | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| James Vernon Harrison | | | Glenda V Woodruff | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| Yes, no, or unknown) | | | | | Hospital Records Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | | |
| 3479 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Aspiration | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Status post Craniotomy | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 344 X Internal Hydrocephalus | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 12-18-68 | | Hydrocephalus | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-17, 1968 to 12-18, 1968, that (I) (we) last saw the deceased alive on 12-18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | | |
| Jonathan M. Williams MD | | | | | | 12-19-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | |
| Jonathan M. Williams MD | | | | | | 808 Terlingua Dr. Silver Spring | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 12-21-1968 | | Cedar Hill | | Suitland Prince Geo Md | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| B.A. Williams 131-11th St SE | | | | | | DEC 23 1968 | | M. J. Jones Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove/carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|--|---|--|---|--|-----------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
OLLIE JENNINGS HARRISON | | | | | 2a. DATE OF DEATH
12 Month 13 Day 68 Year | | 2b. HOUR
9:30 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
7-10-00 | | 6. AGE (In years last birthday)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE (State or foreign country)
VA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wash. San. & Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
md. | | | 13b. COUNTY
PR | | 13c. CITY OR TOWN
Beltsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4421 Powder Mill Rd. | |
| 14. FATHER'S NAME First Middle Last
Walter Harrison | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lillie Greaves | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
578-48-2203 | | 17. INFORMANT
Patients CHart | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the Distal Esophagus</u>
150x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 150x
(b) <u>Leukopenia</u>
(c) <u>Bacteremia</u>
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
(1) <u>Disseminated Disease</u> (2) <u>Emphysema</u> (3) <u>Gastrointestinal bleeding</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
11/22/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Adenocarcinoma of the Distal Esophagus | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November, 1968, to Dec. 13, 1968, that (I) (we) last saw the deceased alive on 12-13-68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Alan R. Gair | | 22c. DATE SIGNED
12/13/68 | | 22d. PHYSICIAN'S NAME (Type)
ALAN R-GAIR MD | | 22e. ADDRESS
3118 Craighawn Rd, Beltsville, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Dec 17, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Pro Geo Md. | | | | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
DEC 18 1968 | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | | | | |

11801

RECORDS OF DEATH

DEC 18 1928
Baltimore

12/19/68 cleared by Dr. Redden Post 10:10 AM
(Medical Examiner)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|------------------------------|---|---|------------------------------------|---|--|------------------------------------|---|--------------------------------------|--|-------------------|--|--------|--|---------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | | |
| EMMA | | | | | | | HARVEY | | DEC. Month 19 Day 1968 Year | | 1004 M | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| FEMALE | | WHITE | | 2/25/1891 | | | | 77 YRS. | | MONTHS | | DAYS | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | | |
| England | | U.S. | | | | | | MONTGOMERY Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| SILVER SPRING. | | | WHEATON NURSING HOME | | | | Housewife | | | Own Home | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | 13f. ADJACENT ST. | | | | | |
| Penna. XXXX | | | XX | | Saratoga | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | XXXXXX XXXXXX XXXXXX | | | XXXXXX | | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First | | Middle | | Last | |
| William | | | | | | | Green | | Emily | | | | | | | Newbold | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | | | | | | |
| Yes, no, or (unknown) | | | 193-40-8252 | | Mrs. George Murrison | | Silver Spring, Md. 1009 Strout Street | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS
4339 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) CEREBRAL ARTERY ATHEROSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
24 HRS
1-2 YEARS | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
332X RECENT LEFT HIP FRACTURE (10/19/68) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | |
| 10/24/68 | | | FRACTURE LEFT HIP. | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 10 19 1968 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
SPONTANEOUS FRACTURE | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.)
HOME | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
AS ABOVE | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from DEC. 19 53, to DEC 19, 19 68, that (1) (we) lost
saw the deceased alive on DEC 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| James A. Roberts M.D. | | | 12/19/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| JAMES A. ROBERTS | | | 8907 GEORGIA AVE. SILVER SPRING, MD. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | | | |
| Burial | | | Dec 21 1968 | | St. Lincoln Cemetery | | | Prince George County, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |
| Warner E. Pumphrey, Inc. 8434 Ga. Ave. | | | DATE DEC 23 1968 | | | | J. Charles Younger | | | | | | | | | | |

3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|------------------------|--|------------------|--|-------|--|------|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 17798 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17809 | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First MIDDLE LAST
ALFRED HARTMANN HAUSRATH | | | | | | | | | | | | | | Month Day Year
12 6 68 | | | | | | | | | | 7:45 P.M. | | | | | | | | | |
| 3. SEX | | | | 4. RACE | | | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | |
| MALE | | | | CAUS. | | | | 7/2/1871 | | | | 97 YRS. | | | | MONTHS | | DAYS | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | | | MONT | | | | | | | | | | | |
| NEW YORK | | | | USA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | |
| WHEATON Md. | | | | UNIVERSITY MRS. NURSING HOME | | | | MUSICIAN | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| Md | | | | MONT | | | | SILVER SPRING | | | | NO | | | | 120 HULLTOP Rd S.S. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First MIDDLE LAST
FREDERICK E HAUSRATH | | | | First MIDDLE LAST
ELIZABETH HARTMANN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | Address | | | | | | | | | | | | | | | | | | | | | |
| | | | | 104-30-1894 | | | | ALFRED HAUSRATH (SON) | | | | 120 HULLTOP RD. S.S. MD. | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4409 Arteriosclerosis, generalized | | | | | | | | | | | | | | Several years | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4500 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960, 19 to December 6, 1968, that (I) (we) last saw the deceased alive on December 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| Bennet A. Porter, M.D. DEGREE | | | | | | | | | | | | | | December 6, 1968 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| Bennet A. Porter, Jr., M.D. | | | | | | | | | | | | | | 9301 Coleville Rd., Silver Spring, Md. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | |
| Cremation | | | | Dec 7, 1968 | | | | St. Luke's Cemetery | | | | Blackshear Manor Park, Md. | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | 25a. RECEIVED BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Arthur Walters | | | | | | | | | | | | | | DEC 9 1968 | | | | | | | | | | Charles Judge | | | | | | | | | |

17808

CHIEF OF POLICE

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17808

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|
| <div>Item 5 Filing 407 12/12/68</div> <div>17799</div> <div>17810</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
MYRTLE | | | Middle
(none) | | | Last
HAVENER | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Dec 2, 1968 | | 6. AGE (In years last birthday)
83 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS
HOURS
MIN. | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> 12 2 1968 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
Montgomery | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | 2c. DATE PRONOUNCED DEAD
Month Day Year
Dec - 22 1968 | | |
| 10. CITY OR TOWN OF DEATH
Potomac | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Falls Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
at Home | | | 12b. KIND OF BUSINESS OR INDUSTRY
at Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Potomac | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
Mason | | | 15. MOTHER'S MAIDEN NAME
Unknown | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16b. SOCIAL SECURITY NO.
None | | |
| 17. INFORMANT
Nora Lee Broches | | | ADDRESS
4264 S. 16th St
Arlington, Va | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4119 IMMEDIATE CAUSE (a) Coronary Insufficiency Acute
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
John G Ball | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | 22b. DATE SIGNED
Dec 2, 1968 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
12-5-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Walkers Chapel Cemetery Arlington, Virginia | | | 23d. LOCATION (City or Town) (County) (State) | | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey Bethesda, Md | | | 7557 Wisconsin Ave | | | 25a. REC'D BY REGISTRAR
DATE DEC 9 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

17810

ALBANY EXAMINER

(Date)

ALBANY, N.Y., Dec. 3, 1883

ALBANY, N.Y.

ALBANY, N.Y.

ALBANY, N.Y.

ALBANY, N.Y.

ALBANY, N.Y.

ALBANY, N.Y.

John J. Hall

1883

1883

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|---------|--|---|--|---|---|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| Herbert King Hawkins | | | | | | ESTIMATED <input checked="" type="checkbox"/> Month Day Year | | 7 P M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | |
| M. | Negro | 6-29-1932 | 36 YRS. | MONTHS DAYS | | HOURS MIN. | | Month Day Year | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 2d. HOUR | | |
| MARYLAND | | U.S.A. | | | | Montgomery | | 3 P M | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Rockville | | 915 Stone Street Ave | | | | Waiter | | None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | Rockville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Pearre Hawkins | | | Cuyler King | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| | | | | | Mrs ERMA L. Sullivan | | Washington D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Laceration and Maceration of Brain</u> | | | | | | | | | Sudden | |
| 965X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) <u>Gun Shot Wound of Head</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 981X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | 7 P.M. Dec. 1968 | | Shot in Head 22 cal gun | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | Car parked in street | | | 915 Stone Street Ave. Rockville Montgomery Md | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | |
| John B. Ball | | | M.D. | | | Dec. 25, 1968 | | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | 12-30-68 | | Brooke Grove Cem | | Laytonsville Montg Md. | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Robert L. Snowden Rockville Md. | | | DATE JAN 3 1969 | | | Charles Judge | | | | |

11871

U.S. DEPARTMENT OF AGRICULTURE

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17891

CERTIFICATE OF DEATH

17812

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Frances Pauline Haxton</i> | | | 2a. DATE OF DEATH
Month <i>12</i> Day <i>27</i> Year <i>68</i> | | | 2b. HOUR
<i>5:35 PM</i> | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>May 25, 1894</i> | | 6. AGE (In years last birthday)
<i>74</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Washington, Va.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Cedar Haven Rest Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Clerk, U.S. Post.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Gov't.</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Boys</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>Route #1 Box 65</i> | |
| 14. FATHER'S NAME First <i>Thomas</i> Middle <i>Wayland</i> Last <i>Wayland</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Mary E.</i> Middle <i>Grimsley</i> Last <i>Grimsley</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>215-46-2082</i> | | 17. INFORMANT Address
<i>Richard Haxton Rt. #1 Box 65, Boys, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>
<i>2509</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Diabetes Mellitus</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i>
<i>Generalized Atherosclerosis</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>12 hrs.</i>
<i>4 yrs.</i>
<i>5 yrs.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>260X</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-25</i> , 19 <i>64</i> , to <i>12-27</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>5:35 PM</i> | | | | | | | | | |
| 22b. SIGNATURE
<i>Howard J. Morse</i> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12-27-68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Howard J. Morse</i> | | | | 22e. ADDRESS
<i>7030 Carroll Ave., Takoma Park, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>12-31-1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>George Washington Cem.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Hyattsville Pr. Georges, Md.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Jr.</i> | | | | ADDRESS
<i>no. 8434 Georgia Avenue</i> | | 50. REC'D BY REGISTRAR
<i>JAN 3 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11812

11811

James (unc) X

JAN 3 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17802 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17813 | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | Hour Min. | | | | | | | | | | | | | | | | | | | |
| MARY E. HAYDEN | | | | | | | | | | DECEMBER 29, 1968 | | | | | | | | | | 1:05 PM | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR | | | | | IF UNDER 24 HRS | | | | | | | | | | | | | | |
| FEMALE | | | | | WHITE | | | | | June 25, 1899 | | | | | 69 YRS. | | | | | MONTHS | | | | | DAYS | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | U.S.A. | | | | | | | | | | Montgomery | | | | | | | | | | Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | |
| Rockville | | | | | Potomac Valley N.H. | | | | | Housewife | | | | | At Home | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Md. | | | | | Montg. | | | | | Rockville | | | | | | | | | | 257 Congressional Lane | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Robert L. Dick | | | | | Elizabeth -- Muir | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | |
| No | | | | | 577-03-3382B | | | | | Charles Hayden, Son, Rockville, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 1560 Metastatic carcinoma, brain, lungs, liver, etc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Primary carcinoma, gallbladder | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1551 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| --- | | | | | | | | | | ----- | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | YES | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> If either, notify medical examiner | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from July 14, 1952, to Dec. 29, 1968, that (I) (we) last saw the deceased alive on Dec. 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | |
| Warren D. Brill, MD | | | | | | | | | | | | | | | Dec 29, 1968 | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | |
| WARREN D. BRILL, M.D. | | | | | | | | | | | | | | | 2601 16th St. N. W. Wash. D. C. 20009 | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | | | | | | | | | 12/31/68 | | | | | | | | | | New Cathedral Com. | | | | | | | | | | Baltimore, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Joseph Gawler's Sons, 5130 Wis. Ave, NW, Wash, DC | | | | | | | | | | | | | | | | | | | | JAN 3 1969 | | | | | | | | | | Charles Judge | | | | | | | | | |

17813

17813 JAN 3 1961

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17814

VR A15ME (5)
10M REV. 1/68

11314

EXHIBIT EXHIBIT EXHIBIT OF DEATH

FOR STATE

HEALTH 1961

21

10

42

10

10

1

10

DEC 5 0 1961

CERTIFICATE OF DEATH

17815

17804

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|-------------------------------------|--|
| 1. DECEASED-NAME
(Type or print) <u>Ruth</u> First <u>U. Herington</u> Middle <u>U.</u> Last <u>Herington</u> | | | 2a. DATE OF DEATH
Month <u>Dec</u> Day <u>9</u> Year <u>1968</u> | | | 2b. HOUR
<u>6:15</u> M | | | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>25 Oct 1893</u> | | 6. AGE (In years last birthday)
<u>75</u> YRS. | | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
DAYS
HOURS
MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
<u>Illinois</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Wheaton, Md.</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Randolph Hills Nursing Home</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Proofreader GPO</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Govt.</u> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>Md.</u> | | | 13b. COUNTY
<u>Mont.</u> | | 13c. CITY OR TOWN
<u>Rockville</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>12501 Plaza Place</u> | | |
| 14. FATHER'S NAME
First <u>Charles</u> Middle <u>--</u> Last <u>Winningham</u> | | | 15. MOTHER'S MAIDEN NAME
First <u>Susan</u> Middle <u>(Unknown)</u> Last <u>(Unknown)</u> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | | 16b. SOCIAL SECURITY NO.
<u>217526753</u> | | 17. INFORMANT
<u>Marion Herington</u> | | Address
<u>12501 Plaza Pl. Rockville, Md.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u>
<u>4129</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>paralyzed arterial sclerosis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 mos</u>
<u>8 yrs</u>
<u>15 yrs.</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4200 upper respiratory infection 2 days</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>12-12-1968</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>upper respiratory infection</u> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March, 1968</u> , to <u>9 Dec, 1968</u> , that (I) (we) last saw the deceased alive on <u>8 Dec, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Merton J. White, M.D.</u> | | | | | | DEGREE
<u>M.D.</u> | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>9 Dec 68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Merton J. White, M.D.</u> | | | | | | 22e. ADDRESS
<u>8911 Georgia Ave Silver Spring, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE
<u>12-12-1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville, Montgomery, Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</u> | | | | | | 25a. REC'D BY REGISTRAR
<u>DEC 16 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Order repeating can 7 2-18 13 years ago 9 km
lost on 27th Nov 68 M. 14th Feb 60.

17013

ENTRANCE IN SLASH

DEC 18 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17895 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17816 | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| First Middle Last
Marcus B Hine | | | | | | | | | | 12 Month 10 Day 68 Year | | | | | | | | | | 12 ⁵⁵ A M | | | | | | | | | | | | | | |
| 3. SEX
Male | | | | | 4. RACE
White | | | | | 5. DATE OF BIRTH
6/21/00 | | | | | 6. AGE (In years last birthday)
68 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Del. Jev. | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Montgomery Md | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp. | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
DC | | | | | 13b. COUNTY
Takoma Park | | | | | 13c. CITY OR TOWN
Takoma Park | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
223 Cedar Street | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
John Hine | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Jean Mc Gruehey | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
No | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
Mrs. Edna E. Hine, 223 Cedar St NW DC | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1621 Carcinomatosis
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 mo
18 mo. | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
163X Pulmonary emphysema - advanced | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from June 1967, to Dec 9, 1968, that (1) (we) lost saw the deceased alive on Dec 9, 1968, and that in (any) (our) opinion death occurred on the date and hour and on the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
James R. Coleman MD | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
Dec. 10, 1968 | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
JAMES R. COLEMAN | | | | | 22e. ADDRESS
9241 COLUMBIA BLVD SILVER SPRING MARYLAND. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE
Dec. 13, 1968 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
National Memorial Park | | | | | 23d. LOCATION (City or Town) (County) (State)
Falls Church VA | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Arthur Walthers, 254 Carroll St NW Wash DC | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR
DEC 12 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | |

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RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|-------------------|--|--|---|--|---|--|---|--|
| Item 6 FilmG408 1/10/69 ts | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 17817 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) GARCIA | | | First Middle Lost | | | 2a. DATE OF DEATH
12 Month 23 Day 68 Year | | 2b. HOUR 5:45 a M | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUS. | | 5. DATE OF BIRTH
10-31-1879 | | 6. AGE (In years, lost birthday) 88 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
OAKLAND, MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONT. COUNTY | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
WHEATON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
UNIVERSITY NURSINGH. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
WAITRESS | | 12b. KIND OF BUSINESS OR INDUSTRY
Rest. | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)
9523 WEST - KENS | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
KENSINGTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
9523 W. Stanhope Rd. | | | |
| 14. FATHER'S NAME
Edward H. Bartlett | | | First Middle Lost | | | 15. MOTHER'S MAIDEN NAME
Elizabeth Fairell | | | First Middle Lost | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
217-18-4832 | | 17. INFORMANT
Helen McIntire Kensington, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Congestive Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c) ?
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4200 Cerebral Vascular Thrombosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1966 , 19____, to present , 19____, that (I) (we) lost saw the deceased alive on Dec 8 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
George Hays M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12/26/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Oakland Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Oakland Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Gerald N. Minnich | | | | | ADDRESS
Oakland, Maryland | | 25a. REC'D BY REGISTRAR
DEC 31 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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DEC 31 1939

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner Dr. Belden R. Reap M.D.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|---|--|--|---|---|
| 1. DECEASED-NAME (Type or print) First <i>Marquerite</i> Middle <i>A.</i> Last <i>Holder</i> | | | | | 2a. DATE OF DEATH Month <i>December</i> Day <i>5</i> Year <i>1968</i> | | | 2b. HOUR <i>M</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>January 5, 1908</i> | | 6. AGE (In years last birthday) <i>60</i> YRS. | | 7. UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN <i></i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>Minnesota</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Takoma Park</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>7411 Hancock Avenue</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Tk. Pk.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>7411 Hancock Avenue</i> | |
| 14. FATHER'S NAME First <i>Robert</i> Middle <i>Harold</i> Last <i>Hobbes</i> | | MOTHER'S MAIDEN NAME First <i>Ira</i> Middle <i>Brooklyn</i> Last <i>Hobbes</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>yes</i> | | 17. INFORMANT <i>Henry Holder 13,814 Woodside Dr. Rockville, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction 1, 4109</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>8 months</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201 None</i> | | | | | | | | | |
| 19a. DATE OF OPERATION <i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>None</i> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 5, 1964</i> to <i>Dec 5, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 5, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Ralph P. Patten</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>December 5, 1968</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Ralph P. Patten</i> | | | | 22e. ADDRESS <i>1407 Woodside Parkway Silver Spring, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>12-9-1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Rockville Montgomery, Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>Warner E. Pumphrey Inc.</i> | | | | ADDRESS <i>8434 Ga. Ave. S.S., Md.</i> | | 25a. REC'D BY REGISTRAR <i>DEC 12 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

17018

OFFICE OF THE SECRETARY OF DEFENSE

17018

1. Name of the person or organization to whom the award is made

2. Title of the award

3. Date of the award

4. Amount of the award

5. Name of the person or organization presenting the award

6. Name of the person or organization receiving the award

7. Name of the person or organization presenting the award

8. Name of the person or organization presenting the award

9. Name of the person or organization presenting the award

10. Name of the person or organization presenting the award

11. Name of the person or organization presenting the award

12. Name of the person or organization presenting the award

13. Name of the person or organization presenting the award

14. Name of the person or organization presenting the award

15. Name of the person or organization presenting the award

16. Name of the person or organization presenting the award

17. Name of the person or organization presenting the award

18. Name of the person or organization presenting the award

19. Name of the person or organization presenting the award

20. Name of the person or organization presenting the award

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expedited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 17808 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17819 | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|---|---|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|
| Item 1, birth cert. in this Div. | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) CONRAD First CHRISTOPHER Middle BOY Last HOLSOMBACK | | | | | 2a. DATE OF DEATH
Month December Day 2 Year 68 | | | | | 2b. HOUR 1208 P M | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Male | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
November 30, 1968 | | | 6. AGE (In years last birthday)
YRS. 1 | | | IF UNDER 1 YEAR
MONTHS 1 DAYS 13 | | | IF UNDER 24 HRS
HOURS 13 MIN 59 | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Bethesda, Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
N/A | | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY
Manassas | | | 13c. CITY OR TOWN
Manassas | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
113 Appomattox Ave. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Conrad Middle Oliver Last Holsomback | | | | | 15. MOTHER'S MAIDEN NAME First Patricia Middle Ann Last Patten | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown N/A | | | 16b. SOCIAL SECURITY NO.
N/A | | | 17. INFORMANT
Address Manassas, Va.
Mr. Conrad O. Holsomback, 113 Appomattox Ave. | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7769 Bilateral atelectasis associated with prematurity
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
7625 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Nov. 30 , 19 68 , to Dec. 2 , 19 68 , that (X) (we) last saw the deceased alive on Dec. 2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
B. J. Bortz, M.D. | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type)
B. J. Bortz, M.D. | | | 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | | 23b. DATE
3 Dec. 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Naval Medical School | | | 23d. LOCATION (City or Town) (County) (State)
NNMC, Bethesda, Montgomery MD | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR
DATE DEC 5 1968 | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Jones | | | | | | | | | | | | | | | | | | | | | | | |

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|-------------------------|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) MARGARET <i>Greely</i> HORTON | | | | | | 2a. DATE OF DEATH
Month 12 Day 9 Year 68 | | | 2b. HOUR 4:40 AM | | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH 11-6-87 | | 6. AGE (In years last birthday) 81 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (State or foreign country) Brownburg Indiana | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHRYSE CHASE CONV CENTER | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, and retired.) Clerical - U.S. Government | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | 13b. CITY OR TOWN MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 8811 Colesville Road | | | |
| 14. FATHER'S NAME First PETER Middle GREELY Last GREELY | | | | 15. MOTHER'S MAIDEN NAME First MARGARET Middle DUGAN Last DUGAN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. 59-60-6719T | | 17. INFORMANT Miss Katherine B. Greely Address 15 Conn. Ave. Wash. D.C. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4319
(b) Arterio sclerosis - generalized
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hours
5 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Nov. 1966 to Dec 9, 1968 , that (I) (we) saw the deceased alive on Dec 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Harry N. Carlton M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 12/9/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) HARRY N. CARLTON | | | | | | 22e. ADDRESS 8811 Colesville Rd, S.S. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE Dec 12 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | 23d. LOCATION (City or Town) (County) (State) Washington, D. C. | | | | | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. | | 24a. ADDRESS 8434 Georgia Avenue Silver Spring, Md. | | 25a. REC'D BY REGISTRAR DEC 12 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

02835

DEPARTMENT OF HEALTH

123

02835

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--------------------------|---|-----------------------------------|--|---|---|-----------------------------------|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
Charles | | | Middle
E. | | | Last
HOWELL | | |
| 2a. DATE KNOWN
OF ESTI-
DEATH | | | Month
Dec. | | | Day
8 | | | Year
1968 | | |
| 2b. HOUR
1000 P | | | 2c. DATE PRONOUNCED DEAD | | | Month
Dec. | | | Day
8 | | |
| 3. SEX
Male | | | 4. RACE
Cauc | | 5. DATE OF BIRTH
Aug. 31, 1943 | | 6. AGE (In years
last birthday)
25 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | |
| Texas | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Montgomery | | Bethesda | | Naval Hospital | |
| 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | 13a. CITY OR TOWN | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET AND NUMBER | | 14. FATHER'S NAME | |
| U. S. Army | | | | Houston | | | | 1602 Antonine Street | | E. V. Howell | |
| 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral lacerations associated with multiple
816.1 skull fractures
Conditions, if any, which gave
rise to immediate cause (a).
stating the underlying cause
lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| Hearn | | ACTIVE DUTY | | UNKNOWN | | E.V. HOWELL | | 1602 ANTONINE ST
HOUSTON, TEXAS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
8254 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year
Hour A.M. 30
P.M. Dec. 19 68 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Passenger in Car. went out of control | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
Street | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
4 or 5 miles south Fredricksburg on Route 17 | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type) | | | | John G. Ball, M. D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | 23b. DATE
12-13-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | | |
| 23d. LOCATION (City or Town) (County) (State) | | | | Houston Texas | | | | 24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS
1400 Chapin St., N. W. Washington, D. C. | | | |
| 25a. REC'D BY REGISTRAR
DATE DEC 20 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

1385

[illegible]

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

71
16
2

MEDICAL CERTIFICATION

| 17841 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17822 | | | | | |
|--|--|------------------------------|--|--|------------------------------------|---|---|---|--|----------------------------|--|-----------------------------------|--------|
| 1. DECEASED-NAME
(Type or print) | | | | First | Middle | Lost | 2a. DATE OF DEATH | | | | 2b. HOUR | | |
| Ms. Madeline | | | | A. | | HOWELL | 12 Month 24 Day 68 Year | | | | 8:40 A.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| F. | | White | | 10-15-1892 | | | 76 YRS. | | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | | Md. | |
| New York | | USA | | WIDOWED | | DIVORCED | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Takoma Park, Mo. | | | | Washington Sanitarium Hospital | | | | House wife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Maryland | | | | Prince George's | | Beltsville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13233 Green mount Ave. | | | |
| 14. FATHER'S NAME | | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | | First | Middle | Lost |
| | | | | | | ACKER | | | | | | | Thelma |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| No | | | | 061-07-5313 | | Chub | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis | | | | | | | | | | | | | |
| 4330 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) Hypertensive Cerebro Vascular disease | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) Arteriosclerosis Generalized | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 332X | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | HOUR A.M. Month Day Year | | | | | | | | | | |
| (If either, notify medical examiner) | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> | | | | | | | | | | | | | |
| at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 17, 1968, to 24 Dec, 1968, that (I) (we) last saw the deceased alive on 23 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR | | STAFF PHYS. | |
| Thomas P. Fogarty | | | | | | | | <input checked="" type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | | | |
| | | | | | | | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | (County) (State) | | | |
| Dec 27-1968 | | | | | Laird Road Cemetery | | | Laird Road | | L.D. NY. | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| J. Edgar Galt | | | | | | 257 Carroll St NW | | DEC 27 1968 | | J. Charles Judge | | | |

17853

OFFICE OF CLERK

17853



DEC 27 1900

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|--|--|--|--|--|---|--|---|--|---|--|--|--|--------------|-----------------------------------|--|--|---|--|--|--|--|---|--|--|--|--|
| Item 8 Film 0108
1/6/69 kk Items 10-222 Film 409 12-30-68
17812 | | | | | | | | | | Item 11 Film 0108 1/13/69 kk
17823 | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or Print)
First Middle Last
JESSE THOMAS HUBBARD | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> 12-30 1968 | | | | | 2b. HOUR
6:30 P.M. | | | | | | | | | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
6-18-01 | | 6. AGE (In years last birthday)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month 12 Day 30 Year 1968 | | | | | 2d. HOUR
7:30 P.M. | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Va | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
In a field at Norbeck Road | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | 13b. COUNTY
Mont. | | | | 13c. CITY OR TOWN
Wheaton | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
15901 Georgia Ave. | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Hartford Hubbard | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Hattie Mae (?) | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
Yes | | | | 16b. SOCIAL SECURITY NO.
229-34-6233 | | | | 17. INFORMANT
Joel D. Hubbard | | | | | | | | | | ADDRESS
11721 Valley Rd Fairfax VA. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Conflagration burns, 2nd and 3rd degree,
958X
DUE TO, OR AS A CONSEQUENCE OF
(b) entire body, self-inflicted
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
979X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
6:00 P.M. 12-30 1968 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
Deceased poured kerosene over himself and set himself afire. | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Farm | | | | 21f. LOCATION Street or R.F.D. No.
Silver Spring | | | | City or Town
Montgomery | | | | State
Md. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Belden R. Reap, MD | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (City, town or county)
Silver Spring, Md. | | | | | | | | | | 22b. DATE SIGNED
DEC. 31, 1968 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | | 23b. DATE
December 31 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Bladensburg Rd. Prince Georges Co. Md. | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
A. Arthur Walters, Jr. | | | | | | | | | | ADDRESS
254 Carroll St NW Wash. D.C. | | | | | | | | | | 25a. REC'D BY REGISTRAR
JAN 2 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Frank L. Hungerford | | | 2a. DATE OF DEATH Dec 28 1968 | | | 2b. HOUR 11 A M | | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH 1-13-00 | | 6. AGE (In years last birthday) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Nebraska | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Teaching | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md. | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Sp. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 515 Thayer Ave. | |
| 14. FATHER'S NAME First Walter Middle -- Last Hungerford | | | 15. MOTHER'S MAIDEN NAME First Ada Middle C. Last Gwin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 4223-48-7394 | | 17. INFORMANT Mrs. Cecile Hungerford | | Address Sil. Spr. Md 515 Thayer Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). Status post-op craniotomy for PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) (b) Glioblastoma Multiforme, right frontal lobe. (c) (a) Pulmonary embolism & complete occlusion of left pulm. artery and partial occlusion of right pulmonary artery. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1939 | | | | | | | | | |
| 19a. DATE OF OPERATION 12/20/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED See 18. | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965 to 12/28 , 19 68 , that (I) (we) last saw the deceased alive on 12/25 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE G. Lennard Gold | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12/28/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) G. Lennard Gold, M.D. | | | | 22e. ADDRESS 9801 Georgia Ave., S.S., Md. 20902 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1-2-1969 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery | | 23d. LOCATION (City or Town) (County) (State) Mt. Morris, Pennsylvania | | | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. | | ADDRESS Sil. Spr. Md. 8434 Georgia Ave. | | 25a. REC'D BY REGISTRAR JAN 3 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

17824

COLLEGE PARK, MARYLAND

1971

(1) ...
(2) ...
(3) ...

12/20/71

JAN 3 1988

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | |
|---|---------------------------|---|---|--|
| 1. DECEASED-NAME
(Type or Print) <i>Edward Scott Hunter</i> | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>12 28 1968</i> | | 2b. HOUR <i>M</i> |
| 3. SEX <i>M</i> | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>5-30-1949</i> | 6. AGE (in years last birthday) <i>19</i> YRS. <i>6</i> MONTHS <i>28</i> DAYS | 7c. DATE PRONOUNCED DEAD <i>12 28 1968</i> |
| 7a. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Sheet-Metal Wks</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Mont. Glen Echo</i> | | 13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME <i>Richard Hunter</i> | | 15. MOTHER'S MAIDEN NAME <i>Beulah McCrossin</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> |
| 16b. SOCIAL SECURITY NO. <i>214-12-7591</i> | | 17. INFORMANT <i>Wife-Virginia</i> | | ADDRESS <i>6421-18th St. Cabin, John, Md.</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Cardiovascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Sudden</i>
<i>years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <i>Dec 28, 1968</i> |
| EXAMINER'S NAME (Type) <i>John G. Ball</i> | | ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <i>12-31-68</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i> | 23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i> | |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> | | ADDRESS <i>7557-Wisconsin Ave., Bethesda, Md.</i> | | 25a. REC'D BY REGISTRAR <i>JAN 9 1969</i> |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>John G. Ball</i> |

11832

THE DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 Filed 12/16/68
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17826

| | | | | | | | | | |
|---|-------------------------|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) Joseph Hopkins Hurley | | | 2a. DATE KNOWN OF DEATH
Month <input checked="" type="checkbox"/> Dec 4 1968 | | | 2b. HOUR
2:45 PM | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
2-22-01 | 6. AGE (In years last birthday)
67 YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month Dec Day 4 Year 1968 | | | 2d. HOUR
2:45 PM |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wash San & Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
lawyer | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
Maryland | | | 13b. CITY
Montgomery | | 13c. CITY OR TOWN
Takoma Pk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
26 Philadelphia Ave |
| 14. FATHER'S NAME
First Peter Middle Hurlay Last | | | 15. MOTHER'S MAIDEN NAME
First Ellen Middle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
wife | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4120 Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Artery Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 Essential Hypertension | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Neaphy | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
DEC. 4, 1968 | |
| EXAMINER'S NAME (Type)
BELDEN R. NEAPHY | | ADDRESS (Street, city, town, or county)
Washington D.C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Dec. 7, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Carmel Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington D.C. | | | |
| 24. FUNERAL DIRECTOR
Arthur Walters | | | | ADDRESS
254 Carroll Ave. Wash DC | | 25a. RECD BY REGISTRAR
DATE
DEC 9 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 17816 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 17827 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) CAROLYN R. IRISH | | | | | 2a. DATE OF DEATH
Month DECEMBER Day 28 Year 1968 | | | 2b. HOUR 11:5 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Feb. 5, 1895 | | 6. AGE (In years last birthday) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Chicago, Ill. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Metallurgist | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3563 So. LEISURE WORLD BLVD. | |
| 14. FATHER'S NAME First Edward Middle Moss Last Ring | | | | | 15. MOTHER'S MAIDEN NAME First Margaret Middle -- Last Schiesbury | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) no | | 16b. SOCIAL SECURITY NO. 579-22-9763 | | 16c. INFORMANT John G. Farlee Address 3114 Spring Drive, Alex., Va. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) leiomyosarcoma c metastases
1719
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) to lung, bone & lymph nodes
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1979 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12/68 , to 12/28/68 19__, that (I) (we) last saw the deceased alive on 12/28/68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Henry C. Scruggs MD. DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 12/29/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) HENRY C. SCRUGGS MD. | | | | 22e. ADDRESS 5413 Cedar Lane Bethesda Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 1-2-1969 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR C. Glen Carter ADDRESS Sil. Spr., Md. | | 25a. REC'D BY REGISTRAR JAN 6 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Ingers | | | | | |
| Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 17817 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17828 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | Hour Minute | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Oliver John Irish | | | | | | | | | | December 7 1968 | | | | | | | | | | 8:45 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | |
| Male | | | | | | | | | | Caucasian | | | | | | | | | | April 2, 1892 | | | | | | | | | | 76 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| Iowa | | | | | | | | | | U. S. A. | | | | | | | | | | | | | | | | | | | | Montgomery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Olney | | | | | | | | | | Montgomery General Hospital Biochemist | | | | | | | | | | Medical Lab | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Montgomery | | | | | | | | | | Silver Spring | | | | | | | | | | | | | | | | | | | | 3563 Leisure World Blvd. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| George Bertram Irish | | | | | | | | | | Sarah Elizabeth Chapman | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | | | | | | | | WW 1 & II | | | | | | | | | | 215-38-6461 | | | | | | | | | | Mrs. Carolyn Irish | | | | | | | | | | 3563 Leisure World Blvd. Silver Spring, Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4109 | | | | | | | | | | IMMEDIATE CAUSE (a) Coronary thrombosis | | | | | | | | | | 5 minutes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease | | | | | | | | | | 6 years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | 4201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1962 to December 7, 1968, that (I) (we) lost saw the deceased alive on December 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| George N. Polis, M.D. | | | | | | | | | | December 8, 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| George N. Polis, M.D. | | | | | | | | | | 1631 16th St., N.W., Wash., D.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | Dec. 11, 1968 | | | | | | | | | | Baltimore National Cem. | | | | | | | | | | Baltimore, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Glen Carter | | | | | | | | | | 8434 Georgia Ave. | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Warner E. Pumphrey, Inc. | | | | | | | | | | Silver Spring, Md. | | | | | | | | | | DEC 12 1968 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

17828

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DEC 11 1960

DEC 11 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| | | | | | | | | |
|--|--|--|---------|---|---|---|--|--|
| 17818 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17829 | | |
| CERTIFICATE OF DEATH | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR P |
| Edward | | | Thawley | Jackson | December 17, 1968 | | 11:30M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH, | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| Male | | White | | May 5, 1913 | | 55 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Maryland | | USA | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | The Clinical Center, NIH | | Usual: Truck Driver | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| Maryland | | Frederick | | Frederick | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 133 South Market St. Apt. 2 |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | |
| Thomas | | | E. | Jackson | Gertrude | Houser | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | 212-17-8461 | | The Medical Records | | | | |
| | | Not available | | The Clinical Center, Bethesda, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | 8 Hours |
| IMMEDIATE CAUSE (a) <u>cerebrum</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carotid Atherosclerosis</u> | | | | | | | | 1 Year |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 332x | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 12/17/68 | | Occlusive Carotid Atheroma | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from December 8, 1968, to December 17, 1968, that (A) (we) last saw the deceased alive on December 17, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | |
| Peter J. Deckers MD | | | | | | 18 December 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | |
| Peter J. Deckers, M. D. | | | | | | The Clinical Center, National Institutes of Health, Bethesda, Md. | | |
| 23a. BURIAL, CREMATION, REBURY (Type) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Buried | | 12/21/68 | | Methodist Cemetery | | Potomac-Montgomery-Maryland | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| M. R. Etchison & Son, Frederick, Md. 21701 | | | | | | DEC 23 1968 | | Charles Judge |

11882

DEPARTMENT OF HEALTH

| | | | | | |
|---------------------|--|-----------------------|--|-----------------------|--|
| Name | | Address | | City | |
| John Doe | | 123 Main St | | New York | |
| Age | | Sex | | Race | |
| 35 | | Male | | Caucasian | |
| Occupation | | Education | | Marital Status | |
| Teacher | | High School | | Married | |
| Date of Birth | | Date of Admission | | Date of Discharge | |
| Jan 15 1900 | | Jan 15 1900 | | Jan 15 1900 | |
| Place of Birth | | Place of Admission | | Place of Discharge | |
| New York | | New York | | New York | |
| Cause of Death | | Cause of Admission | | Cause of Discharge | |
| Heart Disease | | Heart Disease | | Heart Disease | |
| Duration of Illness | | Duration of Admission | | Duration of Discharge | |
| 10 days | | 10 days | | 10 days | |
| Treatment | | Treatment | | Treatment | |
| Medicine | | Medicine | | Medicine | |
| Surgery | | Surgery | | Surgery | |
| Nursing | | Nursing | | Nursing | |
| Diet | | Diet | | Diet | |
| Exercise | | Exercise | | Exercise | |
| Prognosis | | Prognosis | | Prognosis | |
| Good | | Good | | Good | |
| Remarks | | Remarks | | Remarks | |
| Patient recovered | | Patient recovered | | Patient recovered | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|------------------------------|--|
| 17830 | | | | | | | | | | | | |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH 17830 | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Fannibelle Adams Jackson | | | | | | 2a. DATE OF DEATH
Month Day Year
12 10 68 | | | 2b. HOUR
2:05 PM | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
1-20-1896 | | | 6. AGE (In years last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Indiana | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
West Chevy Chase | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
4848 Crescent St. West Chevy Chase, Maryland | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired - Secty. | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
West Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4848 Crescent Street | | | |
| 14. FATHER'S NAME First Middle Last
Jeremiah Adams | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Haley Power | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <input type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT Address
Curtis A. Jackson, Husband, same as #13a. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Carcinoma Ascending colon</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 months</u>
<u>6 months</u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
<u>1530</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
- | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
- | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
- | | 21f. LOCATION Street or R.F.D. No. City or Town County State
- | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>Dec 10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-10-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>P.P. Andrews MD</u> DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12-10-68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>P.P. ANDREWS</u> | | | | | | 22e. ADDRESS
<u>WASHINGTON, DC 20016</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>12-13-1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville, Montgomery Co., Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>Joseph Gawler's Sons, Inc., 5130 Wisconsin Ave., N.W., Wash., D.C., 20016</u> | | | | | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 19 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>gcharles Judge</u> | | | | |

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CERTIFICATE OF DEATH

17820

17831

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME
(Type or print) <i>Bernard L. Johnson</i> | | | 2a. DATE OF DEATH
Month <i>December</i> Day <i>17</i> Year <i>1968</i> | | 2b. HOUR
<i>10:45</i> AM |
| 3. SEX
<i>MALE</i> | 4. RACE
<i>NEGROID</i> | 5. DATE OF BIRTH
<i>6-9-94</i> | | 6. AGE (In years last birthday)
<i>74</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED
<input checked="" type="checkbox"/> NEVER MARRIED
<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | 9. COUNTY OF DEATH
<i>Montgomery County</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Georgetown Lane Nursing Home</i> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>8902 Perz Avenue Silver Spring MD</i> | 13b. COUNTY
<i>MD</i> | 13c. CITY OR TOWN
<i>Silver Spring</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME
<i>John Johnson</i> | 15. MOTHER'S MAIDEN NAME
<i>Mary ?</i> | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i>
<i>485X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>48 hrs</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
<i>491X Rheumatoid arthritis</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> , 19 <i>68</i> , to <i>12/17</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/17</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Myron L. London MD</i> | | 22c. DATE SIGNED
<i>12/17/68</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>2309 Shorefield Rd Wheaton MD</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>12-21-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>GATES OF HEAVEN</i> | |
| 23d. LOCATION (City or Town) (County) (State)
<i>ASPEN Hill Montg Md.</i> | | 24. FUNERAL DIRECTOR
<i>George R. Snowden</i> | | 25a. REC'D BY REGISTRAR
<i>Rockville</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | DATE
<i>DEC 27 1968</i> | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <u>Eleanor</u> <u>Ella</u> <u>Eleanor</u> | | | First <u>M.</u> Middle <u>Johnson</u> Last | | | 2a. DATE OF DEATH
Month <u>Dec.</u> Day <u>1</u> Year <u>1968</u> | | 2b. HOUR <u>3:20P</u> M | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>Aug. 9, 1887</u> | | 6. AGE (In years
at birthday) <u>81</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<u>Illinois</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>2029 Lanier Drive</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>own home</u> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>Md.</u> | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Sil. Spr.</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>2029 Lanier Drive</u> | |
| 14. FATHER'S NAME
First <u>Thomas</u> Middle <u>—</u> Last <u>Kennedy</u> | | | 15. MOTHER'S MAIDEN NAME
First <u>Laura</u> Middle <u>—</u> Last <u>Miller</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <input type="checkbox"/> or unknown <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) <u>--</u> | | 16b. SOCIAL SECURITY NO.
<u>472-52-5659</u> | | 17. INFORMANT
<u>Dorothy J. Carlton</u> | | Address <u>Sil. Spr. Md.</u>
<u>2029 Lanier Drive</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Disease</u>
<u>4109</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cerebral Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Generalized Arteriosclerosis</u>
<u>3</u>
<u>7</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 hrs</u>
<u>3</u>
<u>7</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4221</u> <u>None</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1966</u> to <u>Dec 1, 1968</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Nov 22, 1968</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, <u>(I) (we) (did)</u> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>John S. Rogers, M.D.</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12-2-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>John S. Rogers, M.D.</u> | | | | 22e. ADDRESS
<u>1919 Seminary Road, Sil. Spr. Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 23b. DATE
<u>12-2-1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Lincoln Crematory</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Prince Georges, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc.</u> | | | | ADDRESS
<u>Sil. Spr. Md.</u> | | 25a. REC'D BY REGISTRAR
<u>DEC 5 1968</u> | | 25b. REC'D BY HEALTH DEPT. | |

510

10

2007

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 407 MARYLAND STATE DEPARTMENT OF HEALTH
12-23-68 am DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17833

| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
|---|-------------------------|--|---|---|--|---|---|---|---|-------|
| 1. DECEASED-NAME (Type or Print)
First Middle Last
ROBERT DANIEL JONES | | | | | | 2a. DATE KNOWN OF DEATH
Month Day Year
12-1-68 | | 2b. HOUR
5:40 A.M. | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
7-3-12 | 6. AGE (In years last birthday)
56 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year
12 1 1968 | | 2d. HOUR
5:40 A.M. | | |
| 7a. BIRTHPLACE (State or foreign country)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Management | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurande | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
S.S. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2029 Hanover St. | |
| 14. FATHER'S NAME First Middle Last
Frank O'Donaghue | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Susannah --- Rooney | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | | 16b. SOCIAL SECURITY NO.
298-05-8746 | | 17. INFORMANT ADDRESS
Hercelia Jones, 2029 Hanover St., S.S., Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary occlusion
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, City, Town, or County)
BELOEN R. REAP MD. Silver Spring, Md. | | | | | | | | | | |
| ACTUAL SIGNATURE
BELOEN R. REAP MD. | | EXAMINER'S NAME (Type)
BELOEN R. REAP MD. | | 22b. DATE SIGNED
DEC. 2, 1968 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-4-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring Montgo. Md. | | | | |
| 24. FUNERAL DIRECTOR
M. Andrew Duwall
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | ADDRESS
Sil. Spr. Md. | | 25. REC'D BY REGISTRAR
DEC 6 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

13872

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--------------------------------|--|-------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Angelita Villonco Katigbak | | | | | | 2a. DATE OF DEATH
Month December Day 9 Year 1968 | | | 2b. HOUR 8:05 PM | | | |
| 3. SEX
Female | | 4. RACE
Filipino | | 5. DATE OF BIRTH
30 July 1953 | | | 6. AGE (In years lost birthday)
15 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Philippines | | 7b. CITIZEN OF WHAT COUNTRY?
Philippines | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Student | | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Philippines | | 13b. COUNTY
Makati, Rizal | | 13c. CITY OR TOWN
Makati, Rizal | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
25 Narra Avenue, Forbes/Park | | | | |
| 14. FATHER'S NAME First Middle Last
Arturo Katigbak | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Nelly Villonco | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Record Address
The Clinical Center, NIH, Bethesda, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) E. coli septicemia
2040
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Acute lymphocytic Leukemia
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 Weeks
11 Months | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
2043 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Oct. 14, 1968 , to Dec. 9, 1968 , that (X) (we) last saw the deceased alive on December 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
David H. Riddick, MD | | | | | | 22c. DATE SIGNED
10 December 1968 | | 22d. PHYSICIAN'S NAME (Type) David H. Riddick, Md. | | | | |
| 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
14 Dec. 1968 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State)
MANILA PHILIPPINES | | | | | | |
| 24. FUNERAL DIRECTOR
RINALDI FUNERAL HOME, 7400 GEORGIA AVE. N.W. | | | | | | 25a. REC'D BY REGISTRAR
DEC 13 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

17832

STATEMENT OF DEATH

17832

Deceased: [Name] Date of Death: [Date] Place of Death: [Location]

Age: [Age] Sex: [Sex] Race: [Race] Birth Date: [Date]

Marital Status: [Status] Occupation: [Occupation]

Cause of Death: [Cause] Duration of Illness: [Duration]

Medical History: [History] Previous Conditions: [Conditions]

Attending Physician: [Physician] Hospital: [Hospital]

Signature of Physician: [Signature] Date: [Date]

Signature of Deceased: [Signature] Date: [Date]

Signature of Witness: [Signature] Date: [Date]

Signature of Coroner: [Signature] Date: [Date]

Signature of Registrar: [Signature] Date: [Date]

Signature of [Name]: [Signature] Date: [Date]

Signature of [Name]: [Signature] Date: [Date]

Signature of [Name]: [Signature] Date: [Date]

Signature of [Name]: [Signature] Date: [Date]

Signature of [Name]: [Signature] Date: [Date]

Signature of [Name]: [Signature] Date: [Date]

Signature of [Name]: [Signature] Date: [Date]

Signature of [Name]: [Signature] Date: [Date]

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|------------------------------|--|---|--|---|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) Solomon | | | First M | | | Middle Kaufman | | | Last | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
7-3-96 | | 6. AGE (In years last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and address)
San & Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
SALESMAN | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. COUNTY Montgomery | | | | 13c. CITY OR TOWN Silver Spring | | | |
| 14. FATHER'S NAME
Wolf Kaufman | | | | 15. MOTHER'S MAIDEN NAME
Diane XXXXX | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) yes (If yes give year or dates of service) army W.W. I | | | |
| 16b. SOCIAL SECURITY NO.
219-07-15974 | | | | 17. INFORMANT
MRS. FANNYE LEIBOWITZ, APT. 306, 1001 ROSE SPRING ST. SILVER SPRING, MD | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Head | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
DEC. 8, 1968 | | | |
| EXAMINER'S NAME (Type)
BELDEN R. HEAD | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
12-10-68 | | 23c. NAME OF CEMETERY OR CREMATORY
HAR ZION TIFERETH ISRAEL | | | | 23d. LOCATION (City or Town) (County) (State)
ROSEDALE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | | | 25a. REC'D BY REGISTRAR
DEC 10 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1483

B6E1-011330

1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17825 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17836 | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---------------------|--|------------------------|--|--|-----------------|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2. DATE OF DEATH | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | | |
| R. HARRY KEARNEY, JR. | | | | | | | | | | 12-29-1968 4:15 P M | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS | | | | | | |
| Male | | | Caucasian | | | May 20, 1903 | | | 65 YRS. | | | MONTHS DAYS HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | |
| Wash., DC | | | U.S.A. | | | | | | Montgomery Md. | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| Bethesda | | | Suburban Hospital | | | Ret-Auto Dealer | | | Auto | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Md. | | | Montg. | | | Bethesda | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 10315 Montrose Avenue | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | | | | | | | | |
| R. Harry Kearney | | | Ida - | | | Awkard | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | | | | | | | | | | |
| No | | | 578-05-6358 | | | R. Harry Kearney, III, Same | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Bilateral confluent Bronchopneumonia</i> | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>485X</i> | | | | | | | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | |
| <i>Laennec's Cirrhosis - advanced.</i> | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes.</i> | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 57</i> to <i>12/29, 1968</i> , that (I) (we) last saw the deceased alive on <i>12/29</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>J. Blaine Fitzgerald MD</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <i>12/30/68.</i> | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>J. BLAINE FITZGERALD</i> 22e. ADDRESS <i>8218 Wisc. Ave. Bethesda, Md.</i> | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | |
| Burial | | | 12/31/68 | | | Cedra Hill Cemetery | | | Suitland, Md. | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| Jos. Gawler's Sons, 5130 Wis. Ave, NW, Wash., D.C. | | | | | | | | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR DATE <i>JAN 3 1969</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | | | | | | | | | | | | | | | |

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17836

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17837

| | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|-------------------------|--|--|--|--|---|----------------------|---|--|---|--|---|---------------------------|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First
WILLIAM | | | Middle
HOWARD | | | Last
KEITH | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year
OF ESTI-
DEATH MATED <input type="checkbox"/> 12- 1 68 | | | 2b. HOUR
8:30 P | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
9-1-12 | | 6. AGE (In years last birthday)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year 12 1 1968 | | | 2d. HOUR
8:30 P | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery | | | | Md. | |
| 10. CITY OR TOWN OF DEATH
Olney | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General Hospital | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Electrician | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Electrical | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | 13b. COUNTY
Montgomery | | | | 13c. CITY OR TOWN
Monrovia | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Rt. 1, Box 178 | | | |
| 14. FATHER'S NAME
First Middle Last
Turner Keith | | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Fannie C. Burdette | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, or unknown) Yes No | | | | (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
214-18-5768 | | | | 17. INFORMANT
ADDRESS
Admission Recd, Montgomery Gen. Hospital, Olney | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | | | M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
DEC. 2, 1968 | | | | | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP, M.D. | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, City, Town or County) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
Dec. 4, 1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY
St. Michael's | | | | 23d. LOCATION (City or Town) (County) (State)
Poplar Springs, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Olin L. Molesworth, Damascus, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 5 1968 | | | | 25b. REGISTRAR'S SIGNATURE
H. Charles Judge | | | |

76855

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|--|
| 17837 CERTIFICATE OF DEATH 17838 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) James Henry Kelley | | | 2a. DATE OF DEATH
Month December Day 4 Year 1968 | | | 2b. HOUR 1:00 ^A | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
9 June 1930 | | 6. AGE (In years last birthday)
38 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Draftsman | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE Maryland COUNTY Montgomery | | 13b. CITY OR TOWN
Germantown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Box 193
Cider Barrel Trailer Court | | | | |
| 14. FATHER'S NAME
First Robert Middle S. Last Kelley | | | 15. MOTHER'S MAIDEN NAME
First Maida Middle Ethel Last Hartberger | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
226-32-8071 | | 17. INFORMANT The Medical Records Address
The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gram negative septicemia
7109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septic arthritis
DUE TO, OR AS A CONSEQUENCE OF (c) Psoriatic arthritis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hours
days
years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
720X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3 December, 1968 , to 4 Dec. , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 December , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
J.D. Gardner, M.D. | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-4-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Jerry D. Gardner, M.D. | | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-8-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset View Memo. Gardens | | 23d. LOCATION (City or Town) (County) (State)
Woodstock, Va. | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Lee Fun. Home 300 4th St. NE Wash., D.C. | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles | | | |

17838

BUREAU OF HEALTH

| | | | |
|-------|-------|--------|------------------|
| James | Henry | Keller | December 1, 1908 |
|-------|-------|--------|------------------|

| | | | |
|------|-------|-----------|----|
| Male | White | June 1930 | 38 |
|------|-------|-----------|----|

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| Virginia | USA | Montgomery |
|----------|-----|------------|

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|------------|------------|--------------------|
| Montgomery | Montgomery | The Clinton Center |
|------------|------------|--------------------|

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| Montgomery | Montgomery | Other Federal Health Center |
|------------|------------|-----------------------------|

| | | |
|--------|-----------|--------|
| Robert | E. Kelley | Robert |
|--------|-----------|--------|

| | | |
|-----|------------|--|
| No. | 238-12-001 | The Clinton Center, Hill, Kentucky, Mt. 2001 |
|-----|------------|--|

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| Female | Great, no, white, complexion |
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| Female | Genetic, complexion |
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| Female | Genetic, complexion |
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| Female | Genetic, complexion |
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| Female | Genetic, complexion |
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| Female | Genetic, complexion |
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| Female | Genetic, complexion |
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| Female | Genetic, complexion |
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| Female | Genetic, complexion |
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| Female | Genetic, complexion |
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| Female | Genetic, complexion |
|--------|---------------------|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 17839 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
First Middle Last
Mollie Kekner | | | 2a. DATE OF DEATH
12 Month 27 Day 68 Year | | | 2b. HOUR
11:30 M | | | |
| 3. SEX
Female | | 4. RACE
WHITE | | 5. DATE OF BIRTH
9-1-99 | | 6. AGE (In years
last birthday)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Wash. D.C. | | | 13b. CITY OR TOWN
Wash. D.C. | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1401 Whittier Pl. N.W. | | |
| 14. FATHER'S NAME
First Middle Last
JACOB Rottman | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Gittel Rottman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Robert Kent 6923 Heathhill Rd. Beth. Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA
470x DUE TO, OR AS A CONSEQUENCE OF
(b) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(c) ACUTE "FLU" SYNDROME
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
481x DIABETES MELLITUS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 HOURS
5 HOURS
1 WEEK | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3, 1963, to 12/27, 1968, that (I) (we) last saw the deceased alive on 12/27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Henry R. Wolfe M.D. | | | | DEGREE
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/2 | |
| 22d. PHYSICIAN'S NAME (Type)
HENRY R. WOLFE M.D. | | | | 22e. ADDRESS
1131 UNIVERSITY BLVD. W., S.S. MD. 20902 | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
12/29/68 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Garden | | 23d. LOCATION (City or Town)
Falls Church | | (County) (State)
Va. | |
| 24. FUNERAL DIRECTOR
Bernard Dargatzis + Son | | | | ADDRESS
5001 14th St N.W. Wash DC | | 25a. REC'D BY REGISTRAR
JAN 2 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

11830

OFFICE OF THE

THE SECRETARY OF THE
TREASURY
WASHINGTON, D. C.

TO THE SECRETARY OF THE
TREASURY
WASHINGTON, D. C.

FROM THE SECRETARY OF THE
TREASURY
WASHINGTON, D. C.

SUBJECT: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MONTGOMERY COUNTY, MARYLAND
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 17829 | | | | | | 17840 | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | 2a. DATE OF DEATH Month Day Year | | | | 2b. HOUR | |
| Andrew J Kessinger | | | | | | 12 3 68 | | | | 3:30 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| M | | W | | 4/22/78 | | 90 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Missouri | | U.S.A. | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | | | Colonial Villa Nursing Home | | | | Real Estate | | builder | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | | Mont. | | Hensington | | YES | | 3333 University Blvd. W. | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Francis M. Kessinger Sr. | | | | (Unknown) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | | | 214-03-9843 A | | Jackson A. Kessinger | | Sil. Spr. Md.
700 Notley Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1538 Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebral Embolism | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 days
74 hr.
204 hr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
1538 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased, from June 3, 1946, to Dec 3, 1968, that (I) (we) last saw the deceased alive on Nov 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 3:30 AM 12/3/68 | | | | | | | | | | | |
| 22b. SIGNATURE LOB Wardrop MD | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12/3/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Wm B. Wardrop | | | | | | 22e. ADDRESS 800 Pershing Drive, Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 12-6-1968 | | Parklawn Cemetery | | Rockville Montgomery Md. | | | | | |
| 24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | | 25a. REC'D BY REGISTRAR DEC 6 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

17040

RECORDS OF THE

888 2030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared By Medical Examiner

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------------|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|--|--|
| 17831 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 17842 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Aina S. Finefield | | | | | | | | | | | | 2a. DATE OF DEATH Month Day Year
12-17-68 | | | | | | | | | | | | 2b. HOUR
12 P-M | | | | | | | | | | | |
| 3. SEX
Female | | | | 4. RACE
Caucasian | | | | 5. DATE OF BIRTH
12-28-88 | | | | 6. AGE (In years lost birthday)
79 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
School Teacher | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Wash. D.C. | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
1358 Langford St. NW | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Michael Hayden | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Katherine Keeyes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
no | | | | 16b. SOCIAL SECURITY NO.
579-60-2483 | | | | 17. INFORMANT Address
Hospital Records | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 Days ? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
7201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.
19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1968 to 12/17/68, that (I) (we) last saw the deceased alive on 16 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
William D. Aud | | | | | | | | | | | | DEGREE
ATTENDING PHYS. | | | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | | | 22c. DATE SIGNED
12/17/68 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
WILLIAM D. AUD | | | | | | | | | | | | 22e. ADDRESS
9006 COLESVILLE ROAD SIL. SP. MD. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMAINS (Specify)
BURIAL | | | | 23b. DATE
12-19-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
MT OLIVET CEMETERY | | | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON D. C. | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR COLLINS FUNERAL HOME ADDRESS
500 University Blvd. W. SILVER SPRING, MD. | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DEC 20 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 11-1-68
45M - 1969

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 17832 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17843 | | | |
| 1. DECEASED-NAME (Type or print) <i>Dorothea R. Kinsey</i> | | | | | | 2a. DATE OF DEATH
Month <i>12</i> - Day <i>19</i> - Year <i>68</i> | | 2b. HOUR <i>6:15 P.M.</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH
<i>2-8-12</i> | | 6. AGE (In years last birthday)
<i>56</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | | Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Waitress</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Gaithersburg</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>435 E. Diamond Street</i> | |
| 14. FATHER'S NAME First <i>Charles</i> Middle <i>Ran</i> Last <i></i> | | 15. MOTHER'S MAIDEN NAME First <i>Nellie</i> Middle <i>Smith</i> Last <i></i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <i>215-14-7458</i> | | 17. INFORMANT <i>Buddy B. Kinsey</i> | | Address <i>1607 Marshall Rd. Rockville Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
Coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <i>4201</i>
(b) <i></i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>48 hours</i>
<i>48 hours</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>Sub</i>
<i>Acute yellow atrophy, liver & renal failure secondary to above.</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11 Dec</i> , 19 <i>68</i> , to <i>19 Dec</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9 Dec</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Frederick S. Caldwell</i> MD DEGREE | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/26/68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>FREDERICK S. CALDWELL</i> | | | | 22e. ADDRESS
<i>Rockville, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>12-23-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St Rose Church</i> | | 23d. LOCATION (City or Town) <i>Gaithersburg</i> (County) <i>Montgomery</i> (State) <i>Md</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Ernest C. Gartner</i> | | | | ADDRESS
<i>Gaithersburg Md.</i> | | 25a. REC'D BY REGISTRAR
<i>DEC 26 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

11843

UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
MARTIN HENRY KINSINGER | | | | | 2a. DATE OF DEATH
12 Month 3 Day 68 Year | | | 2b. HOUR
8:45 P.M. | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
3-7-1901 | | 6. AGE (In years lost birthday)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
WASH. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON SANDS HOSP. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Gov't. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
TAKOMA PARK | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
657-Houston Ave. | |
| 14. FATHER'S NAME First Middle Last
M. HENRY Kinsinger | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Florence -- Devlin | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO.
217-07-9213 | | 17. INFORMANT Address
Lois M. Kinsinger 657 Houston Avenue, Jak. Pk. Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
441.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 451.X
(b) Massive Right Ventricular Embolism 5 minutes
DUE TO, OR AS A CONSEQUENCE OF
(c) Pulmonary Embolism
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Post Resection + graft Replacement of Ruptured Abdominal Aortic Aneurysm | | | | | | | | | |
| 19a. DATE OF OPERATION
11/26/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Rupture Aortic Aneurysm | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/26, 1968 , to 12/3, 1968 , that (I) (we) last saw the deceased alive on 11/25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Marvin L. Kolkin M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/4/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
MARVIN L. KOLKIN | | | | | 22e. ADDRESS
1015 Spring Street, S.E., Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-7-1-968 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland Pr. Georges, Md. | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | 25a. REC'D BY REGISTRAR
DEC 12 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

17044

DEC 15 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

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|---|--|---|--|--|--|
| 17834 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 17845 | |
| 1. DECEASED-NAME (Type or print) GEORGE First Middle Last NMI KIRK | | | | 2a. DATE OF DEATH Month December Day 24 Year 1968 | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH October 2, 1920 | |
| 7a. BIRTHPLACE (State or foreign country) Czechoslovakia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (In years and months) 48 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Foreign Service | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Bethesda | |
| 14. FATHER'S NAME First Middle Last George --- Kirichenko | | 15. MOTHER'S MAIDEN NAME First Middle Last Not Available | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes W.W.II | | 16b. SOCIAL SECURITY NO. 055-14-7668 | | 17. INFORMANT Address Martha Kirk, Wife, Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY ATHEROSCLEROSIS FEW YRS.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18/68 to 12/24/68 , that (I) (we) last saw the deceased alive on 12/18/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE G. Lennard Gold REGISTEE | | | | 22c. DATE SIGNED 12/25/68 | |
| 22d. PHYSICIAN'S NAME (Type) G. Lennard Gold | | | | 22e. ADDRESS 9801 Georgia Ave, Silver Spring, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial/Transit | | 23b. DATE 12/28/68 | | 23c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery | |
| 23d. LOCATION (City or Town) Queens, Long Island, N.Y. | | 23e. (County) Queens | | 23f. (State) N.Y. | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, 5130 Wis. Ave, Wash., D.C. | | 25a. REC'D BY REGISTRAR DEC 30 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (urban papers) pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| 17835 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | CERTIFICATE OF DEATH | | 17846 | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Manuel</i> First <i>Etta</i> Middle <i>Kissinger</i> Last | | | 2a. DATE OF DEATH
Month <i>Dec</i> Day <i>22</i> Year <i>68</i> | | | 2b. HOUR <i>22:00</i> PM | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>4/26/1896</i> | | 6. AGE (In years last birthday) <i>72</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Pa.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Chorist</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Drug St.</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i> | | 13b. COUNTY <i>Mont</i> | | 13c. CITY OR TOWN <i>Chevy Chase</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER <i>4623 Rowwood Dr.</i> | | 14. FATHER'S NAME First <i>John</i> Middle <i>J.</i> Last <i>Riegel</i> | | 15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Jane</i> Last <i>Montgomery</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>578-14-1273</i> | | 17. INFORMANT <i>Martin J. Kissinger</i> | | 18. ADDRESS <i>4623 Rowwood Dr. Chevy Chase, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis</i>
<i>5990</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>UTI - urinary tract infection</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>6092</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>CVA, ASHD Cardio-vascular accident - Heart Vessels</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>12-10-1968</i> to <i>12-22-1968</i> , that (I) (we) last saw the deceased alive on <i>12-22-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>John S. Saia</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>22 Dec 68</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>JOHN S. SAIA</i> | | | | 22e. ADDRESS <i>809 viers mill Rd, S.S., Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>12-26-1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Peters Church Cemetery Loyalton</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Dauphin Pa.</i> | |
| 24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i> | | | | 25a. REC'D BY REGISTRAR <i>DEC 26 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i> | |

MEDICAL CERTIFICATION

17880

OFFICE OF THE

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17836

17847

| | | | | | | | |
|--|--|---|---|---|--|--|--------------------|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Lost | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 12 23 1968 | | 2b. HOUR
7:20 A |
| DORA | | KLINE | | | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
Dec. 25, 1891 | 6. AGE (In years
last birthday)
76 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month 12 Day 23 Year 19 68 | 2d. HOUR
7:20 A |
| 7a. BIRTHPLACE (State or foreign
country)
Poland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery | | Md. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Holy Cross Hospital | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
housewife | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Sil/Sprg. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
815 Wesley Ave. SSMD. | | | |
| 14. FATHER'S NAME
First Middle Lost
Nathan Kline ? | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
none | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | 17. INFORMANT
son in law Milton Charnow 11215 Oak Leaf Dr. SSMD. | ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Multiple Extreme Injuries</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>(Internal) with Exsanguination</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>814.7</u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>812.4</u> | | | | | | | |
| 19a. DATE OF OPERATION
<u>812.4</u> | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year
7:20 A.M. 12-23 19 68 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)
<u>Deceased, a pedestrian, was
struck by auto in street.</u> | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE
AT WORK | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
<u>Street</u> | 21f. LOCATION Street or R.F.D. No.
<u>Ha. Ave. & Cameron St.</u> | City or Town
<u>Silver Spring</u> | County
<u>Montg.</u> | State
<u>MD</u> | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)
<u>BELOEN R. REAP, M.D.</u> | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, City or County)
<u>Washington</u> | 22b. DATE SIGNED
<u>DEC. 23, 1968</u> | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE
<u>DEC. 24, 1968</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Park Cemetery</u> | 23d. LOCATION (City or Town)
<u>Paramus, New Jersey</u> | (County) | (State) | | |
| 24. FUNERAL DIRECTOR
<u>Donald M. Stein</u>
<u>Hebrew Memorial Funeral Home</u> | ADDRESS
<u>232 Carroll St., N.W. Wash., D.C.</u> | 25a. REC'D BY REGISTRAR
<u>DEC 27 1968</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | |

17847

MINICA EXAMINATION CENTER OF CLINIC

FOR STATE
OFFICIALS

DEC 23 1988
K. J. [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17837 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17848 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|---|--|--|--|--|-------------------------------|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last
ERNEST F KNIGHTING | | | | | | | | | | Month Day Year
12 24 68 | | | | | | | | | | 10 30 PM | | | | | | | | | |
| 3. SEX
M | | | 4. RACE
W | | | 5. DATE OF BIRTH
4-1-88 | | | 6. AGE (In years last birthday)
80 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
VA. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | |
| 1d. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired- Standard Brands | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Mont. | | | 13c. CITY OR TOWN
S.S. | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
8403 Hartford Ave. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First Middle Last
John Knighting | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Betty Suthern | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | | | | 16b. SOCIAL SECURITY NO.
578-05-0813A | | | | | 17. INFORMANT
Margaret A. Knighting Wife Same as #13 | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute Bronchopneumonia, bilateral</u>
485X
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
491X Rostic ulcer - pulmonary emphysema | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner)
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 11, 1968, to 12-24, 1968, that (I) (we) last saw the deceased alive on 12-24 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
D.L. Bucy | | | 22c. DATE SIGNED
12-25-68 | | | 22d. PHYSICIAN'S NAME (Type)
D.L. Bucy | | | | | | | | | | | | | | | | | | | | | | | |
| 22e. ADDRESS
809 Veirs Mill Rd. Rockville Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
12-28-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Maryland. | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Francis Hallis | | | 500 University Blvd W
Silver Spring, Md | | | 25a. REC'D BY REGISTRAR
DEC 30 1968 | | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | | | | | | | | | | | | | | | | | | | | |

84871

ALSO SEE: (RIP)

8381 04 030

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17888 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17849 | | | | | | | | | |
|---|--|--|-----------|--|--|------------------|--|--|---------------------------------|---|--|-----------------|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First Middle Last | | | | | 20. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| INFANT | | | | | Koehler | | | | | Month Day Year | | | | | 12 23 68 | | | | | 30 12 PM | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| male | | | Caucasian | | | 12-23-68 | | | — YRS. | | | MONTHS DAYS | | | HOURS MIN | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| Md. | | | | | | | | | | | | | | | Montgomery Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Silver Spring | | | | | Holy Cross | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Md. | | | | | P.G. | | | | | Hyatts. | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 5112 41st Ave. | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| RONALD GARY KOEHLER | | | | | GLENDA LOU BOWMAN | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | | | | | | | | | | | |
| | | | | | | | | | | mother | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Prematurity | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7691 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) premature rupture of membr. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7615 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | |
| | | | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/20, 1968, to Jan. 19, 1969, that (I) (we) last saw the deceased alive on 12/23/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | ATTENDING PHYS. | | | | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | |
| C.R.A. Gilbert | | | | | | | | | | | | | | | | | | | | 30 Dec 68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| C.R.A. Gilbert | | | | | | | | | | 344 Univ. Blvd W. Sping | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 12/30/68 | | | | | Gate of Heaven Cemetery | | | | | Silver Spring Montg. Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Tyson Wheeler F.H., 1331 Rockville Pike, Rockville, Md. 20854 | | | | | | | | | | | | | | | | | | | | DATE JAN 3 1969 | | | | | Charles J. J. | | | | |

17533

RECEIVED

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OFFICE OF THE SECRETARY OF THE ARMY

1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17830

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17850

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
Koehler "8" | | | 2a. DATE OF DEATH
Month 12 Day 23 Year 68 | | | 2b. HOUR
12³⁰ PM | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
12-23-68 | | 6. AGE (In years last birthday)
YRS. — MONTHS — DAYS — HOURS — MIN 32 | |
| 7a. BIRTHPLACE (State or foreign country)
M.D. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Huatts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
5112 41st Ave | | 14. FATHER'S NAME First Middle Last
Ronald Gary Koehler | | 15. MOTHER'S MAIDEN NAME First Middle Last
Glenda Lou Bowman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Mother | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
7691
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Premature rupture of mem.
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
7615 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. — — — 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/22, 1968 to 12/23, 1968 , that (I) (we) last saw the deceased alive on Jan 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
C.R.A. Gilbert | | DEGREE
— | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/30/68 | |
| 22d. PHYSICIAN'S NAME (Type)
C.R.A. Gilbert | | 22e. ADDRESS
344 Univ Blvd W. Spkyd | | | | | |
| 23a. BURIAL, CREMATION, REPOURIFICATION
Burial | | 23b. DATE
12/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring Montg. Md. | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler F. H. 1331 Rockville Pike | | | | ADDRESS
Rockville, Maryland | | 25a. REC'D BY REGISTRAR
DATE JAN 3 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

13830

EXHIBIT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|-------------------------|
| 17840 | | | | | 17851 | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Mr. Gerald Morris Koenig | | | | | 2a. DATE OF DEATH
Month 12 Day 13 Year 1968 | | | | | 2b. HOUR 5:48 PM |
| 3. SEX Male | | 4. RACE White-Caucasian | | 5. DATE OF BIRTH 2/24/1911 | | | 6. AGE (In years last birthday) 57 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Printer - G.P.O. | | | 12b. KIND OF BUSINESS OR INDUSTRY Government | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 9307 Ocala St. | | |
| 14. FATHER'S NAME First Charles Middle -- Last Koenig | | | | | 15. MOTHER'S MAIDEN NAME First Katherine Middle -- Last Muchek | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) No | | (If yes give war or dates of service) -- | | 16b. SOCIAL SECURITY NO. 122-88-5840 | | 17. INFORMANT Laura S. Koenig | | Address 9307 Ocala St., Silver Spring, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gram neg. Bacteremic shock | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) Associated Condition Bacteremic Ca. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 1621 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-22 , 19 68 , to 12-13 , 19 68 , that (I) (we) last saw the deceased alive on 12-13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Lewis Dennis MD | | | | | DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED DEC 13, '68 | | | |
| 22d. PHYSICIAN'S NAME (Type) LEWIS DENNIS MD | | 22e. ADDRESS 3906 BEL PRE RD, SILVER SPRING | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-17-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Hills Cemetery | | 23d. LOCATION (City or Town) (County) (State) Philadelphia, Pennsylvania | | | | |
| 24. FUNERAL DIRECTOR J.W. Lee Jr. | | ADDRESS Sil. Spr., Md. | | 25a. REC'D BY REGISTRAR DEC 23 1968 | | 25b. REGISTRAR'S SIGNATURE J. Warner E. Pumphrey | | | | |
| Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 9, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

17841

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17852

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or Print) <i>John Charles Kohlenberg</i> | | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 12-12 1968 | | | | 2b. HOUR 9:30 M | | | |
| 3. SEX <i>male</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH <i>1924</i> | | 6. AGE (In years last birthday) <i>44</i> YRS. | | 7c. DATE PRONOUNCED DEAD <i>Dec. 12</i> 1968 | | 2d. HOUR 10:45 M | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Labour</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Bojds</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>Box 39</i> | |
| 14. FATHER'S NAME First <i>John</i> Middle <i>Thomas</i> Last <i>Kohlenberg</i> | | | | 15. MOTHER'S MAIDEN NAME First <i>Georgia</i> Middle <i>Turner</i> Last <i>Turner</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>WW II Army</i> | | | | 16b. SOCIAL SECURITY NO. <i>217-28-7970</i> | | 17. INFORMANT <i>John P. Kohlenberg</i> | | ADDRESS <i>14 Montgomery Ave Bethesda</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Smoke inhalation and burns, second degree</i>
<i>890X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>9160</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year <i>9:30 P.M. 12 12 1968</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>trapped in house fire</i> | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i> | | 21f. LOCATION Street or R.F.D. No. <i>18529 Strawberry Knoll</i> City or Town <i>Gaithersburg</i> County <i>Mont.</i> State <i>Md.</i> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John B. Ball</i> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <i>Dec 13, 1968</i> | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>12-16-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i> | | 23d. LOCATION (City or Town) <i>Ballsville</i> (County) <i>Mont</i> (State) <i>Md</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i> | | | | ADDRESS <i>Gaithersburg, Md.</i> | | | | 25a. RECD BY REGISTRAR <i>DEC 19 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

13831

UNITED STATES DEPARTMENT OF HEALTH

HEALTH DEPT

UNITED STATES DEPARTMENT OF HEALTH

DEC 10 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17842

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last
Eva Stella Kowalsky | | | 2a. DATE OF DEATH
Month Day Year
December 4 1968 | | 2b. HOUR
M
7:15 |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
16 July 1905 | | 6. AGE (In years last birthday)
63 YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Poland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE
West Virginia | | 13b. COUNTY
Raleigh | 13c. CITY OR TOWN
Raleigh | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
Box 234 |
| 14. FATHER'S NAME First Middle Last
John Ligocki | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Haratyk | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
233-30-9912 | | 17. INFORMANT Address
The Medical Records The Clinical Center, NIH, Bethesda, Md. 20014 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gram negative sepsis
DUE TO, OR AS A CONSEQUENCE OF infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal obstruction - probably bowel /
DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent cancer of uterus
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours
1829 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
174X | | | | | |
| 19a. DATE OF OPERATION
7/18/68 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cancer of uterus | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that he (this hospital) attended the deceased from 23 Nov. , 19 68 , to 4 Dec. , 19 68 , that he (we) last saw the deceased alive on 4 December , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE
H. Bryan Neel, III, M.D. | | | DEGREE
M.D. | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED
4 December 1968 |
| 22d. PHYSICIAN'S NAME (Type)
H. Bryan Neel, III, M.D. | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
12-7-68 | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Beckley West Virginia | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey | | ADDRESS
7557 isconsin Bethesda, Md | | 25a. REC'D BY REGISTRAR
DATE
DEC 9 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

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ABSTRACT

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The Clinical Center

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THE CLINICAL CENTER FOR THE STUDY OF

no. 10-00000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------------------|-------------------|---|--|---|--|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 17844 | | | | | | 17855 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring | | | | c. LENGTH OF STAY IN 1b - years - | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8484 16th Street; Apt #908 | | | | | | d. STREET ADDRESS 8484 16th Street | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ELLA | | | First Middle Last | | | 4. DATE OF DEATH DECEMBER 22 1968 | | | Day Year | | |
| 5. SEX Female | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 15, 1888 | | 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Russia | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Zalman Murnik | | | | | | 14. MOTHER'S MAIDEN NAME Chaya | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Jeanette Goldman | | | Address 2212 Ross Road Silver Spring, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS
4339 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332 (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE; DIABETES MELLITUS
INTERVAL BETWEEN ONSET AND DEATH 10 DAYS | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that (I) (this hospital) attended the deceased from MAY 28, 1960 , to DECEMBER 22, 1968 , that (I) (we) last saw the deceased alive on Dec-21 1968 , and that death occurred at 4:45 AM , from the causes and on the date stated above. | | | | 22a. SIGNATURE Israel Kessler M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 22b. DATE SIGNED 12/22/68 | | | | 22c. PHYSICIAN'S NAME (Type) ISRAEL KESSLER, M.D. | | | | 22d. ADDRESS 5801-16th St. N.W., WASH., D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF Dec. 24, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden | | | 23d. LOCATION (City, town or county) (State) Falls Church, Va. | | |
| 24. FUNERAL DIRECTOR Bernard Danzaksy & Sons | | | | ADDRESS 3501-14th St. N.W. Wash., D.C. 20010 | | | | 25a. REC'D BY REGISTRAR DEC 30 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

SALT LAKE COUNTY, UTAH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|---|---|---|--|---|--------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
M | | |
| DeSales | | | Ann K. Lacey | | | Dec. 23 1968 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Female | | White | | 11-14-14 | | 54 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Md. | | | | |
| Penn. | | USA | | | | Montgomery | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Takoma Park | | | Wash. Hospital & San | | | Housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Montgomery | | Wheaton | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3300 Medway St. | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | |
| John Carey | | | Bridget Clark | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address | | | | | |
| No | | | | | DeSales Ann Lacey | | Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 hr</u>
<u>3 days</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>193X) cirrhosis liver</u> <u>2) malnutrition</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/1/68</u> , 19 <u>68</u> , to <u>12/23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/23/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Patrick C. Jameson</u> DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/24/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
Patrick C. Jameson | | | | | 22e. ADDRESS
<u>11718 Georgia Silver Spring Md</u> | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 12/27/68 | | Gate of Heaven | | Silver Spring, Mont Md. | | | | |
| 24. FUNERAL DIRECTOR
Collins Funeral Home | | | | | ADDRESS
500 University Blvd. W.
Silver Spring, Md. | | 25a. REC'D BY REGISTRAR
DATE
DEC 30 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|---|---|----------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First
Elizabeth | | | Middle
NMN | | | Last
Ladson | | | |
| 2. DATE OF DEATH | | | Dec. Month 17 Day 68 ^{or} | | | 2b. HOUR
2:55 ^{PM} | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
11-20-18 | | | 6. AGE (In years last birthday)
50 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Olney | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
3007 Olney-Sandy Spring Rd. | | |
| 14. FATHER'S NAME
First Middle Last
Alexander McGill | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Lois Nicholson | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | | | 16b. SOCIAL SECURITY NO.
Unknown | | | 17. INFORMANT
Hospital Records | | | Address
Olney, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> | | | | | | | | | | 2 hrs | | |
| 5719 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bleeding Esophageal Varices</u> | | | | | | | | | | 2 days | | |
| (c) <u>Carcinoma of Liver</u> | | | | | | | | | | 6 mos | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
5810 <u>Uremia</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (the doctor) attended the deceased from <u>12/16</u> , 19 <u>68</u> , to <u>12/17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Dr. Charles Ligon</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/17/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Charles Ligon | | 22e. ADDRESS
Sandy Spring Md 20860 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-20-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn | | | 23d. LOCATION (City or Town)
Rockville | | (County)
Mont. | | (State)
Md. | |
| 24. FUNERAL DIRECTOR
Francis H. Barber | | | | ADDRESS
Laytonsville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE <u>12/23 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|----------------------|--|--|
| <div>17847</div> <div>CERTIFICATE OF DEATH</div> <div>17858</div> | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
DONATA E. LANAHAN | | | | | | 2a. DATE OF DEATH Month Day Year
12 26 68 | | | 2b. HOUR
9:30 A M | | |
| 3. SEX
FEMALE | | 4. RACE
White | | 5. DATE OF BIRTH
7-25-89 | | 6. AGE (In years last birthday)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
W. VA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring, Md. | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Govt., U.S. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11411 Viers Mill Rd. | |
| 14. FATHER'S NAME First Middle Last
Thomas -- Ortnan | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
(Unknown) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Cornelius E. Lanahan 11411 Viers Mill Road Wheaton, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 TERMINAL PULMONARY EDEMA
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral Vascular Accident (Embolic)
DUE TO, OR AS A CONSEQUENCE OF
(c) Arterio-Sclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
7 days
5 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)
4200 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-10, 1965, to 12/26/68, 1968, that (I) (we) last saw the deceased alive on 12/26/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Francis X. Richanson M.D.
DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/26/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
FRANCIS X. RICHANSON | | | | | | 22e. ADDRESS
11412 Viers Mill Road Silver Spring Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-30-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Montgomery. Md. | | | | | |
| 24. FUNERAL DIRECTOR
J. W. Lee Judge
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | | 25a. REC'D BY REGISTRAR
JAN 3 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

15828

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner Dr. Belden Reay

MEDICAL CERTIFICATION

| | | | | |
|---|--|---|---|---|
| 1. DECEASED-NAME
(Type or print) Clarence A. Lawrence | | 2a. DATE OF DEATH
Month December Day 2 Year 1968 | | 2b. HOUR
4 A M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
September 16, 1891 | 6. AGE (In years last birthday)
77 YRS. | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Nebraska | 7b. CITIZEN OF WHAT COUNTRY?
U S A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Fairland Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Air Force Depart. | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Sil Spr. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
2803 Hathaway Terrace |
| 14. FATHER'S NAME
First Franklin Middle A. Last Lawrence | 15. MOTHER'S MAIDEN NAME
First Jennie Middle - Last Dean | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | |
| 16b. SOCIAL SECURITY NO.
464-24-7646 | 17. INFORMANT
Address Sil. Spr., Md.
Mildred Stewart 2803 Hathaway Terrace | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia + resp depression
1890
DUE TO, OR AS A CONSEQUENCE OF
(b) Wide spread metastases
DUE TO, OR AS A CONSEQUENCE OF
(c) Renal carcinoma
180X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Weeks
Months
Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Uremic coma | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 4, 1968 , to Dec 2, 1968 , that (I) (we) last saw the deceased alive on Nov 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Richard P. Delaney | DEGREE
MD | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
12/2/1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Richard P. Delaney | 22e. ADDRESS
4323 Harvard Street Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
12-5-1968 | 23c. NAME OF CEMETERY OR CREMATORY
St. Lincoln Cemetery | 23d. LOCATION (City or Town) (County) (State)
Prince Georges, Maryland | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | ADDRESS
8434 Georgia Avenue | | 25a. REC'D BY REGISTRAR
DEC 6 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

6 4 1

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| <div>17819</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>17860</div> | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|----------------------------|---|--|
| 1. DECEASED-NAME
(Type or print) Albert E. Leef | | | | | | 2a. DATE OF DEATH
Month 12 Day 30 Year 68 | | | 2b. HOUR
12:48 M | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
6-9-1920 | | 6. AGE (In years last birthday)
48 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Naval Research | | 12b. KIND OF BUSINESS OR INDUSTRY
Engineer | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4403 Edgetfield Rd. | | | |
| 14. FATHER'S NAME
First Henry Middle Albert Last Leef | | | | 15. MOTHER'S MAIDEN NAME
First MARY Middle TERRY Last Williams | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) yes | | 16b. SOCIAL SECURITY NO.
577-12-6335 | | 17. INFORMANT
Elvira Lois Leef - same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Acute coronary thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 5 years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19, 68 , to Dec 30, 1968 , that (I) (we) last saw the deceased alive on Nov. 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Observed with medical examiner | | | | | | | | | | | |
| 22b. SIGNATURE
Robert N. Coale MD | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Dec 30, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT N. COALE | | | | 22e. ADDRESS
4429 Bradley Lane, Chevy Chase Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
1-4-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory, | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Prince Georges County, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | | | 25a. REC'D BY REGISTRAR
DATE JAN 3 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

178871

RECEIVED

1971

(1)

(2)

1. The first part of the report is a summary of the work done during the year. It is a very brief summary, but it gives a good idea of the work done.

2. The second part of the report is a detailed account of the work done during the year. It is a very detailed account, but it is written in a very clear and concise manner. It is a very good example of a report.

3. The third part of the report is a summary of the work done during the year. It is a very brief summary, but it gives a good idea of the work done.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
30M REV. 1-58

| | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|
| 17850 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17861 | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Sophie Charlotte Link | | | | | | 2a. DATE OF DEATH Month Day Year
Dec 4, 1968 | | 2b. HOUR
6:25 PM | | |
| 3. SEX
Female | | 4. RACE
Cauc | | 5. DATE OF BIRTH
Dec 10, 1880 | | 6. AGE (In years last birthday)
87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Hamburg | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
University of Maryland | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Montgomery Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
98 Eldrid Drive | | |
| 14. FATHER'S NAME First Middle Last
Henry -- Kreienberg | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Marie -- Henck | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
135-09-7528D | | 17. INFORMANT Address
Maryland Sil. Spr. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Coronary occlusion, acute sudden
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis, coronary & genit. organs.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 1) Anemia, auto-hemolytic 2) Diabetes mellitus | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June, 1950, to Dec. 4, 1968, that (I) (we) last saw the deceased alive on Nov. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Philip H. Varner, M.D. | | | | DEGREE
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12-14-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Philip H. Varner, M.D. | | | | 22e. ADDRESS
10620 Georgia Ave., Wheaton, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Cremation | | 23b. DATE
12-7-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Lincoln Crematory | | 23d. LOCATION (City or Town) (County) (State)
Prince Georges Maryland | | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | C. Glen Carter | | ADDRESS
Sil. Spr. Md. | | 25a. REC'D BY REGISTRAR
DEC 12 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

1981

1981

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--------------------------|--|---|--|--|--|----------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| Item 6 Film 407 12/23/68 kk | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 17851 | | | | | | | | | |
| 17862 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| ROBERT REYNOLDS LOGAN | | | | | | December 14 1968 | | | 12:10 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | Caucasian | | 26 JAN 1913 | | 34 55 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Indiana | | USA | | | | Montgomery County, Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda, Md. | | U. S. Naval Hospital | | USN | | USN | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Vest-Mary's | | Lexington Park | | | | 314 Midway Drive | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Robert M. LOGAN | | | Leatha REEVES | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| Yes | | | 359 20 2912 | | Eva Ella LOGAN (Wife) Lexington Park, Md. 314 Midway Dr., | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>METASTATIC ADENOCARCINOMA OF STOMACH</u>
<u>1519</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Multiple Abdominal Abscesses with Diffuse</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Adhesions and Peritonitis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>151X</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>21 August</u> , 19 <u>68</u> , to <u>14 Dec.</u> , 19 <u>68</u> , that <u>X</u> (we) last saw the deceased alive on <u>14 Dec</u> , 19 <u>68</u> , and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>X</u> (we) (did) <u>(did not)</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>K. R. Matheis</u> DEGREE | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) <u>K. R. MATHEIS MD (LT MC USN)</u> | | | | | 22e. ADDRESS <u>Naval Hospital, Bethesda, Maryland</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 12/18/68 | | Arlington National Cemetery | | Arlington, Va. | | | |
| 24. FUNERAL DIRECTOR <u>Robinson Funeral Home, Leonardton, Md.</u> ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | | DATE <u>DEC 18 1968</u> | | <u>J. Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
45M - 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|---|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Ellen Hennings LYONS | | | | | | 8 December 1968 | | 9:55A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | |
| Female | | Cauc | | 15 Feb 1913 | | 55 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Washington, D.C. | | USA | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | Naval Hospital | | | Housewife | | DOMESTIC | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | CHARLES | | Bryans Rd. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rt. 1, Box 167 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Frederick HENNINGS | | | Virgie Anna BURGESS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | 577-07-5044 | | Chester A. LYONS, Rt 1, Box 167, Bryans Rd, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 442X Intra-abdominal hemorrhage | | | | | | | | | 2 hours | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Rupture of false aneurysm of right common iliac artery | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 452X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 8 December, 1968, to 8 December 1968, that (X) (we) last saw the deceased alive on 8 December 1968, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | |
| J. A. Routenberg Lt/MC | | | | | | | | 9 December 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | |
| J. A. ROUTENBERG | | | | | | Naval Hospital, Bethesda, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | 11 Dec 1968 | | Cedar Hills Cemetary | | Suitland, Pr. Georges, Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Huntt Funeral Home, Waldorf, Maryland | | | | DEC 13 1968 | | Charles Judge | | | | |

11883

RECEIVED

DEC 11 1988

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1-69

| 17853 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 17864 | |
|--|---|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Cecil W. Macy</i> | | | 2a. DATE OF DEATH
Month <i>Dec.</i> Day <i>22</i> Year <i>1968</i> | | 2b. HOUR
<i>4:20 P.M.</i> |
| 3. SEX
<i>male</i> | 4. RACE
<i>white</i> | 5. DATE OF BIRTH
<i>2/28/1944</i> | | 6. AGE (In years last birthday)
<i>24</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
<i>Iowa</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>Montgomery</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban Patient Examiner</i> | | 12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Cost.</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Mont.</i> | 13c. CITY OR TOWN
<i>Bethesda</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>6721 Grosvenor Lane</i> |
| 14. FATHER'S NAME
First <i>Cecil</i> Middle <i>W.</i> Last <i>Macy</i> | | 15. MOTHER'S MAIDEN NAME
First <i>Lillian</i> Middle <i>Wang</i> Last <i>Wang</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
<i>yes. U.S. Army</i> | | 16b. SOCIAL SECURITY NO.
<i>216-46-1918</i> | 17. INFORMANT
<i>Jean Talbot Washington D.C.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Massive pulmonary embolism</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1/2 hours</i> |
| 1538
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Emboli from thrombosis, right femoral vein.</i> | | | | | <i>2 days</i> |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Post-surgical resection carcinoma, colon</i> | | | | | <i>10 days</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>1538</i> | | | | | |
| 19a. DATE OF OPERATION
<i>Dec 11 68</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Carcinoma colon</i> | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>yes</i> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>DEC 8</i> , 1968, to <i>DEC 22</i> , 1968, that (I) (we) lost saw the deceased alive on <i>DEC 22</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Robert G. Brewer MD</i> | | | | 22c. DATE SIGNED
<i>12/22/68</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>ROBERT G. BREWER</i> | | | | 22e. ADDRESS
<i>8505 Old Georgetown Rd. Bethesda Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Buried</i> | | 23b. DATE
<i>Dec 27, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rock Creek Cemetery</i> | |
| 23d. LOCATION (City or Town)
<i>Washington</i> | | (County)
<i>D.C.</i> | | (State) | |
| 24. FUNERAL DIRECTOR
<i>Arthur Walters, 254 Carroll St NW Wash DC</i> | | | | 25. REC'D BY REGISTRAR
DATE <i>DEC 27 1968</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

MEDICAL CERTIFICATION

17862

17862

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

CERTIFICATE OF DEATH

State of New York, County of New York, City of New York, I, the undersigned, being a duly qualified physician, do hereby certify that on the 1st day of January, 1901, at New York City, New York, died _____, of the County of New York, State of New York, aged _____ years, _____ months, and _____ days, of _____, and that the death was caused by _____.

Witness my hand and the seal of my office this _____ day of _____, 1901.

Physician

Attorney General

DEC 1 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Richard OSWALD MAI | | | 2a. DATE OF DEATH Month Day Year
December 28 1968 | | | 2b. HOUR
9 15 P. M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
11-29-1891 | | 6. AGE (In years last birthday)
77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Delaware | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Coburn Villa Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Banker | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Delaware | | 13b. COUNTY
SUSSEX | | 13c. CITY OR TOWN
Greenwood | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
MARKET | |
| 14. FATHER'S NAME First Middle Last
CHARLES FREDERICK MAI Dec | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ANNA MARIE KOEHLER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown
Unknown | | 16b. SOCIAL SECURITY NO.
221-09-4381A | | 17. INFORMANT
R. EVERETT MAI | | Address
570 HAWKSBURY LANE
Silver Spring, Md 20904 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
486X DUE TO, OR AS A CONSEQUENCE OF
(b) _____
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
493X malnutrition, dehydration, chronic brain syndrome arterio/sclerosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/2, 1967, to 12/28, 1968, that (I) (we) lost saw the deceased alive on 12/13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R.H. Sandstrom MD | | DEGREE | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/28/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
R.H. Sandstrom MD | | 22e. ADDRESS
7701 Carroll Ave SE & K Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
12-31-68 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. JOHNSTOWN CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
GREENWOOD SUSSEX DEL. | | | |
| 24. FUNERAL DIRECTOR
William Flischnauer | | ADDRESS
Greenwood | | 25a. REC'D BY REGISTRAR
JAN 2 1969 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

1971

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 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and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

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|--|--|--|-------------------|---|-------------------|
| 17855 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 17866 | |
| Item#7bFilm#G408 12/31/68 vmp | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | 2a. DATE OF DEATH |
| Sarah | | | Markman | | Month Day Year |
| Dec. 20 1968 | | | 1. A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Female | | White | | 9/18/1882 | |
| 6. AGE (In years last birthday) | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| 86 YRS. | | | | Montgomery Md. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Russia | | U.S.A. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| Wheaton | | Randolph Hills Nursing Home | | housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | MONTGOMERY | | BETHESDA | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| | | 5820 Durbin Road | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| First Middle Last | | First Middle Last | | | |
| Aaron Chudek | | Baila Rasha | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| (If yes give war or dates of service) | | 216-01-6999-D | | Mrs. Beverly Zitelman | |
| | | | | Address 5820 Durbin Road Bethesda, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) Arteriosclerotic Heart Disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| Diabetes Mellitus | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| | | Hour A.M. Month Day Year | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/18/67, 1967, to 12/20, 1967, that (I) (we) lost the deceased alive on 12/19, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| R. T. Bena CK MD | | 12/20/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| R. T. Bena CK MD | | 4115 Colie Dr. Wheaton Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | DEC. 22, 1968 | | Hebrew Young Men's Cemetery | |
| 24. FUNERAL DIRECTOR | | 23d. LOCATION (City or Town) (County) (State) | | 25a. REC'D BY REGISTRAR | |
| Donald M. Stein | | Baltimore, Maryland | | DEC 24 1968 | |
| Hebrew Memorial Funeral Home | | St. N.W. Wash., D.C. | | Charles Judge | |

1888

CLINICAL OF DEATH

1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-54
30M REV 1-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 17856 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
<i>Richard N Martin</i> | | | | | 2a. DATE OF DEATH Month Day Year
<i>Dec 23 1968</i> | | | 2b. HOUR MIN
<i>12:45 PM</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>8/13/93</i> | | 6. AGE (In years last birthday)
<i>75</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>West. Va.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Montgomery</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Retired</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md</i> | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>7005 Old Gate Road</i> | |
| 14. FATHER'S NAME First Middle Last
<i>Richard Martin</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Lennie Williams</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give War or dates of service)
<i>None</i> | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
<i>Richard Martin</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>METASTATIC CARCINOMA</i>
<i>185X</i> DUE TO, OR AS A CONSEQUENCE OF
(b) <i>CARCINOMA OF PROSTATE</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 YEAR</i>
<i>4 YEARS</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>177X MYOCARDIAL INFARCTION 1964</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>DEC 29, 1962</i> , to <i>DEC 25, 1968</i> , that (I) (we) last saw the deceased alive on <i>DEC 23, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Michael S. Madeloff</i> 197 DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
<i>12/23/68</i> | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>MICHAEL S. MADELOFF</i> | | | | | 22e. ADDRESS
<i>10620 Georgia Ave. Silver Spring, Maryland</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| <i>Burial</i> | | <i>12-26-68</i> | | <i>Parklawn Cemetery</i> | | <i>Rockville, Maryland</i> | | | |
| 24. FUNERAL DIRECTOR ADDRESS
<i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | | | | 25a. REC'D BY REGISTRAR
<i>JAN 2 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J Charles Judge</i> | | |

MEDICAL CERTIFICATION

17881

10-10-1944

1944

10

10-10-1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17868

| | | | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--------------------------------|--|--|
| 1. DECEASED NAME
(Type or print) <i>Rosemary Catherine Marvel</i> | | | 2a. DATE OF DEATH
Month <i>December</i> Day <i>20</i> Year <i>1968</i> | | | 2b. HOUR
<i>5:50 P.M.</i> | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>4/2/25</i> | | 6. AGE (In years lost birthday)
<i>43</i> YRS. | | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS.
HOURS <i></i> MIN. <i></i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>District of Columbia United States</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery County</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Washington Sanatorium Hospital</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>own home</i> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Wheaton</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>2814 Hardy Avenue</i> | | | |
| 14. FATHER'S NAME
First <i>Michael</i> Middle <i>J.</i> Last <i>McKnight</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Rosemary</i> Middle <i>Doemling</i> Last <i>Doemling</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>218-42-4808</i> | | | 17. INFORMANT
<i>Un. E. Marvel, Jr.</i> | | | Address <i>2814 Hardy Ave.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Hepatic Coma. Pneumonia</i>
<i>5710</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Severe Cirrhosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>alcoholism</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>5811 Upper D.S. Bleeding</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>5/20/68</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Upper D.S. Bleeding</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i>
P.M. <i></i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1968</i> , to <i>Dec 20, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 20, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>R. Bufalino MD</i> | | DEGREE <i>MD</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>Dec 21, 68</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>RUSSELL BUFALINO MD</i> | | 22e. ADDRESS
<i>1429 University Blvd W.</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>12-24-1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Silver Spring, Montg. Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | ADDRESS
<i>8434 Georgia Avenue</i> | | 25a. REC'D BY REGISTRAR
<i>DEC 26 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | |

80851

10/10/1941

(M)

(1)

80851

CERTIFICATE OF DEATH

17858

17869

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|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Edgar | | | First Paul | | | Middle Mason | | | Last | | | 2a. DATE OF DEATH
Month Dec Day 24 Year 1968 | | | 2b. HOUR
12 PM | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
3/06/05 | | | 6. AGE (In years last birthday)
63 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
Mt Vernon Ill. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
sign painter | | | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
SSMd. | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
1516 Jasper St. SSMd. | | | | | |
| 14. FATHER'S NAME
First Noel Middle -- Last Mason | | | 15. MOTHER'S MAIDEN NAME
First Mary Middle -- Last Shade | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes (no, or unknown) No (If yes give war or dates of service) -- | | | 16b. SOCIAL SECURITY NO.
578-24-8493 | | | 17. INFORMANT
Eulah C. Mason | | | Address
1516 Jasper St. SSMd. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction (Murmur)
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Coronary Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Coronary Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Myocardial Infarction old 1957-1959-1962 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
11/22/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Chronic Coronary Arteriosclerosis | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1949 , to Dec 24, 1968 , that (I) (we) last saw the deceased alive on Dec 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
George L. Ball | | | DEGREE
MD | | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | | MED. DIRECTOR <input type="checkbox"/> | | | STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
Dec 24, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
George L. Ball | | | 22e. ADDRESS
10620 Germantown Rd Silver Spring, Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
12-28-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Rockville Montgomery Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
J. W. Lee | | | ADDRESS
Sil. Spr., Md. | | | 25a. REC'D BY REGISTRAR
Jan 3 1969 | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | | | | |
| VR A15 (1) 30M REV. 11-68 | | | Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | | | | | | | | | | |

THIS COPY HAS BEEN CLASSIFIED BY Beldun P. Medical Examiner with authority to sign. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|---|---|---|-----------------------------------|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 17859 17870 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Elwine J. Matre</i> | | | | | | 2a. DATE OF DEATH
Month <i>12</i> - Day <i>29</i> - Year <i>68</i> | | | 2b. HOUR
<i>10:40 PM</i> | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>6-19-96</i> | | 6. AGE (In years last birthday)
<i>72</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Ohio</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY <i>Montgomery</i> | | | 13c. CITY OR TOWN
<i>Silver Sp.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>1904 Rookwood Rd.</i> | |
| 14. FATHER'S NAME
First <i>Gustavus</i> Middle <i>Junkerman</i> Last <i>Pearl</i> | | | | 15. MOTHER'S MAIDEN NAME
First <i>Pearl</i> Middle <i>Hall</i> Last <i>Hall</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) <i>xxx</i> | | | 16b. SOCIAL SECURITY NO.
<i>Not Known</i> | | 17. INFORMANT
<i>Mrs Robert Long</i> | | Address
<i>Cincinnati Ohio</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| <i>4201</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/13, 1968</i> to <i>12/29, 1968</i> , that (I) (we) last saw the deceased alive on <i>12/29, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Sidney J. Malawer</i> | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/29/68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>SIDNEY J. MALAWER, M.D.</i> | | | | | | 22e. ADDRESS
<i>8218 Wisconsin Avenue, Bethesda, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>1/02/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Spring Grove Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Cincinnati Ohio</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>ROBERT A. PUMPHREY,</i> | | Bethesda, Maryland | | 7557 Wisconsin Ave. ADDRESS | | 25a. REG'D BY REGISTRAR
<i>JAN 6 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John D. Judge</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|-----------------------------------|--|--|
| <div> <div>17860</div> <div>17871</div> </div> <div>CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) FRANCES GERALDINE MATTERS | | | | | | 2a. DATE OF DEATH
Month DECEMBER Day 18 Year 1968 | | | 2b. HOUR
2:40P M | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
SEPT 18, 1899 | | 6. AGE (In years last birthday)
69 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN | |
| 7a. BIRTHPLACE (State or foreign)
MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
NAVAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
MARYLAND PRINCE GEORGE'S | | | 13c. CITY OR TOWN
HYATTSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3450 TOLEDO TERR | | | | |
| 14. FATHER'S NAME
First WILLIAM Middle F. Last RUANE | | | 15. MOTHER'S MAIDEN NAME
First NELLIE Middle CONNOLLY Last CONNOLLY | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) NO
(If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
579-48-4266 | | 17. INFORMANT
HUSBAND HAROLD P. MATTERS | | 3450 TOLEDO TERR
HYATTSVILLE, MD | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pending further study of central nervous system</u> | | | | | | | | | | | |
| -DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>Asthmatic bronchitis-clinical</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| <u>500X</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>DEC 17</u> , 19 <u>68</u> , to <u>DEC 18</u> , 19 <u>68</u> , that <u>XX</u> (we) last saw the deceased alive on <u>DEC 18</u> , 19 <u>68</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (we) (did) <u>(XXX)</u> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>M. Schenk</u> | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
20 DECEMBER 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
T. M. SCHENK, M.D. | | | | | | 22e. ADDRESS
NAVAL HOSP(TAL, BETHESDA, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
Dec 23, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
ARLINGTON VIRGINIA | | | | |
| 24. FUNERAL DIRECTOR
GASCH'S SONS | | | | | | 4739 BALTIMORE AVE
HYATTSVILLE, MD. | | 25a. REC'D BY REGISTRAR
DATE DEC 24 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 17861 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17872 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| James Howard Mattox, Jr. | | | | | | | | | | December 5, 1968 | | | | | | | | | | 3:45 M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | 7. UNDER 1 YEAR | | | | | | | | | | 7. UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Male | | | | | | | | | | White | | | | | | | | | | 8 March 1959 | | | | | | | | | | 9 YRS. | | | | | | | | | | MONTHS | | | | | | | | | | DAYS | | | | | | | | | | HOURS | | | | | | | | | | MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| South Carolina | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Montgomery | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bethesda | | | | | | | | | | The Clinical Center | | | | | | | | | | Student | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| South Carolina | | | | | | | | | | | | | | | | | | | | Ridgeway | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | P. O. Box 181 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| James Howard Mattox, Sr. | | | | | | | | | | Virginia Miles | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | None | | | | | | | | | | The Medical Record | | | | | | | | | | The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Pseudomonas septicemia | | | | | | | | | | hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2750 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | neutropenia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) Dysgammaglobulinemia, chronic hypoplastic/ | | | | | | | | | | years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 287.2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Extensive necrotizing pseudomonal ulcerating lesion right forearm | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 2 Dec. 1968, to 5 Dec. 1968, that (X) (we) last saw the deceased alive on 5 December 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Richard A. Johnson | | | | | | | | | | 5 December 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Richard A. Johnson, M.D. | | | | | | | | | | The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 12.7.68 | | | | | | | | | | Aimwell Cemetery | | | | | | | | | | Ridgeway S. Carolina | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Lee Funeral Home | | | | | | | | | | 300.4th st N E D C. | | | | | | | | | | DATE DEC 9 1968 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 17862 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17873 | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
<i>Anna F Mawhinney</i> | | | 2a. DATE OF DEATH
Month Day Year
<i>12 23 68</i> | | | 2b. HOUR
<i>5A M</i> | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>Nov 19, 1899</i> | | 6. AGE (In years last birthday)
<i>69</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>New Jersey</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville, Md</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Potomac Valley Hosp Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Retired Gov't Employee</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>4905 Ertter Drive</i> | | 14. FATHER'S NAME
First Middle Last
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Mary Forsyth</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <i>No</i>
(If yes give war or dates of service) <i>***</i> | | 16b. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Robert F. Mawhinney, Jr. San Deigo, Cal</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>4409</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 days</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4500 Parkinson's disease</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 15, 1968</i> to <i>Dec 23, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 23, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Dr Joseph P. Kenrick MD</i> | | | | 22c. DATE SIGNED
<i>12/23/68</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>DR JOSEPH P. KENRICK</i> | |
| 22e. ADDRESS
<i>6450 Wisconsin Ave, Bethesda, Md.</i> | | | | 22f. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>12/26/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arlington Nat'l Cem.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Arlington, Virginia</i> | |
| 24. FUNERAL DIRECTOR
<i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | | | 25a. REC'D BY REGISTRAR
<i>JAN 2 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17803 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17874 | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
JEANETTE E MAX | | | | | | | | | | 2a. DATE OF DEATH
12 Month 26 Day 1968 Year | | | | | | | | | | 2b. HOUR
10:15 P.M. | | | | | | | | | |
| 3. SEX
FEMALE | | | | | 4. RACE
WHITE | | | | | 5. DATE OF BIRTH
DEC. 11, 1890 | | | | | 6. AGE (In years last birthday)
78 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | | | IF UNDER 24 HRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
New Jersey | | | | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
CHERRY WILSON 59 & CONV. CENTER | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
473 | | | | | 13b. COUNTY
WASHINGTON | | | | | 13c. CITY OR TOWN
WASHINGTON | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
4000 Col Aedra Ave. NW | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Julius Ellis | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Anne Jones | | | | | 17. INFORMANT
DAUGHTER
MRS. JANICE GOLDBERG-7835 ORCHID ST NW | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
DAUGHTER
MRS. JANICE GOLDBERG-7835 ORCHID ST NW | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 485X
DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHOPNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c) 2 days | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
491X PARKINSONISM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April, 1935, to Dec, 1968, that (I) (we) last saw the deceased alive on 12-26-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
Marvin Fuchs MD | | | | | | | | | | 22c. DATE SIGNED
12-26-68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Marvin Fuchs | | | | | 22e. ADDRESS
MD 6201 Robin Wood Rd. Beth Md | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | | 23b. DATE
12-30-68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | | | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON DC | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
BERNARD DANZANSKY & SONS | | | | | ADDRESS
WASHINGTON DC | | | | | 25a. REC'D BY REGISTRAR
JAN 2 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17875

| | | | | | |
|--|--|--|---|--|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
FRANCIS HENRY MAY | | | 2a. DATE OF DEATH
Month Day Year
December 5 1968 | | 2b. HOUR
9:00 AM |
| 3. SEX
MALE | | 4. RACE
WHITE | 5. DATE OF BIRTH
September 2 1887 | | 6. AGE (In years last birthday)
81 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
STATZIRLE N.Y. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. |
| 10. CITY OR TOWN OF DEATH
OLNEY | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Brooke Grove Foundation | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
TRAFFIC SUPERVISOR | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
New York | | 13b. COUNTY
Bronx | | 13c. CITY OR TOWN
Bronx | |
| 14. FATHER'S NAME First Middle Last
HARRY MAY | | 15. MOTHER'S MAIDEN NAME First Middle Last
ESTELLE T. ROAL | | 16. SOCIAL SECURITY NO.
067-03-0335 | |
| 17. INFORMANT
Mr. Gordon May | | Address
14804 Wakefield Dr. Rockville Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute coronary
157.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer pancreas, inoperable
DUE TO, OR AS A CONSEQUENCE OF (c) with ascites & obstructive jaundice
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10-15"
4 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
157x mild anemia, malnutrition | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 4, 1968 to Dec 5, 1968 , that (I) (we) last saw the deceased alive on Nov 22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
John R. Spencer | | DEGREE
MD. | | 22c. DATE SIGNED
12-5-68 | |
| 22d. PHYSICIAN'S NAME (Type)
John R. Spencer | | 22e. ADDRESS
15444 Columbia Road
Burtonsville, Maryland 20730 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE
12/7/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler | | ADDRESS
1331 Rockville Pike
Rockville, Maryland | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Montg. Md. | |
| 25a. REC'D BY REGISTRAR
DEC 6 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1737

1737

1737



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|---------|---|--|---|---|---|--|--------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| MAURICE | | | S. MAY | | | 12-14-1968 | | | 1:00 a M |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| MALE | WHITE | | March 1, 1891 | | | 77 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Wash. D. C. | | U. S. A. | | | | MONTGOMERY | | | MD. |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BETHESDA | | | SUBURBAN | | | ARCHITECT | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MARYLAND | | | MONTGOMERY | | CHEVY CHASE | | 3920 OLIVER STREET | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| GEORGE MAY | | | ROSINA SAUL | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| NO | | | 5-79-26-6888 | | MRS. EVELYN S. MAY | | Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>1704 CARCINOMA of left HUMERUS</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>1964 liver Disease with decompensation</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| None | | None | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>None</u> | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
<u>None</u> | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>September 1, 1961</u> , to <u>December 14, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 14, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>James M. Loftus M.D.</u> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/14/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>JAMES M. LOFTUS</u> | | | | | 22e. ADDRESS
<u>5415 CONN. AVE. N. W. WASH. D.C.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | 12-16-68 | | GATE OF HEAVEN | | | SILVER SPRING MD. | | |
| 24. FUNERAL DIRECTOR <u>COLLINS FUNERAL HOME</u> ADDRESS <u>500 UNIV. BLVD. W. SILVER SPRING, MARYLAND</u> | | | | | 25a. REC'D BY REGISTRAR
<u>DEC 18 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

37871

QUEST. CONTRA



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888.8.830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--------------------------|---|-----------|--|--|--|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| 17886 | | | WILLIAM | S. | Mc Andrew | 12 Month 7 Day 68 Year | | | 6:30 P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| MALE | | WHITE | | Aug. 29, 1882 | | 86 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Kentucky | | U.S.A. | | | | MONTGOMERY | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CHEVY CHASE | | BETHESDA SILVER SPRING N.B. HOME | | Gov. T. WALKER | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| DE MO. | | MONT. | | SUMNER | | | | 5109 NAWANT ST. N.W. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| ROBERT | | | | | SIMON | MARY O'DONOVAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address |
| No | | | 579-60-1811-T | | | (DAUGHTER) MARY C. O'BRAZNEY | | | SAME AS 13 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Heart failure | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| 4129 | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) Arteriosclerosis of Heart | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 4200 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov, 1968, to Dec 7, 1968, that (I) (we) last saw the deceased alive on Nov 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| [Signature] | | 12/7/68 | | J.E. Fitzgerald | | | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | | | | | | |
| 3500 Reservoir Rd | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | 12-10-68 | | FATE OF HEAVEN CEM. | | WHEATON | | MD. | |
| 24. FUNERAL DIRECTOR | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | |
| H. Don | | 2222 | | WASH. D.C. | | | | | |
| DEVOL'S | | WISCONSIN AVE. | | DEC 11 1968 | | J. Charles Judge | | | |

11871

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
<i>Lila</i> | | | Middle
<i>J.</i> | | | Last
<i>Mc Cathran</i> | | | 2a. DATE OF DEATH
Month
<i>Dec.</i> Day
<i>28</i> Year
<i>1968</i> | | | 2b. HOUR
<i>9⁰⁵ A M</i> | | |
| 3. SEX
<i>Female</i> | | | 4. RACE
<i>White</i> | | | 5. DATE OF BIRTH
<i>4-12-1874</i> | | | 6. AGE (In years last birthday)
<i>94</i> YRS. | | | IF UNDER 1 YEAR
MONTHS
<i></i> DAYS
<i></i> | | | IF UNDER 24 HRS.
HOURS
<i></i> MIN.
<i></i> | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>VA.</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>MONTGOMERY</i> Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Kensington</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Kensington Gardens Sanit</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>House wife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>AT HOME</i> | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | | 13b. COUNTY
<i>MONTGOMERY</i> | | | 13c. CITY OR TOWN
<i>Wheaton</i> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
<i>2810 HARDY AVE.</i> | | | | | |
| 14. FATHER'S NAME
First
<i>Thomas</i> Middle
<i>W. Anderson</i> Last
<i></i> | | | 15. MOTHER'S MAIDEN NAME
First
<i>ELIZA</i> Middle
<i></i> Last
<i>Cannon</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
<i>NO</i> | | | | | | 16b. SOCIAL SECURITY NO.
<i>215-54-5143</i> | | | 17. INFORMANT
Address
<i>6 Farrell Rd. (Hospital records)</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>ASHD & H CVD</i>
<i>4120</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>443X</i>
(b) <i></i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 yrs</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>AS cerebro-vasc. disease secondary anemia</i> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-27-1967</i> to <i>12-28-1968</i> , that (I) (we) saw the deceased alive on <i>12-22-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>G. F. Sengstack M.D.</i> | | | 22c. DATE SIGNED
<i>12-28-68</i> | | | 22d. PHYSICIAN'S NAME (Type)
<i>G. F. SENGSTACK</i> | | | 22e. ADDRESS
<i>9241 COL. BLVD., SILVER SPRING, MD.</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | | 23b. DATE
<i>12/31/68</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>CONGRESSIONAL Cem.</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>WASHINGTON, D.C.</i> | | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Jos. GAWLER'S SONS, 5130 WIS. AVE. NW, WASH., D.C.</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>JAN 2 1969</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | | | | | | |

81371

RECEIVED OF DEATH

899

JAN 1 1989

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|
| Item 18 Film 408 1-13-69a | | | | | | | | | | |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 17879 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Elizabeth Bliss McClendon | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| 3. SEX Female | | | | | 4. RACE White | | | 5. DATE OF BIRTH 6/27/14 | | |
| 6. AGE (In years last birthday) 54 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Idaho | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. COUNTY OF DEATH Montgomery | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | | | | 13b. CITY OR TOWN Potomac | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last George H Bliss | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Tuxbury | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown | | | | | 16b. SOCIAL SECURITY NO. - | | | 17. INFORMANT Husband Glenn McClendon | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac arrest | | | | | 2 hours | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypoxia | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) Mucus plugs and aspirated vomitus in bronchioles | | | | | 2 hours | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 493x (d) Pneumonia, pulmonary atelectasis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-13, 1968, to 12-23, 1968, that (I) (we) last saw the deceased alive on 12-23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE W. G. Hall | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 12/23/68 | | |
| 22d. PHYSICIAN'S NAME (Type) W. G. Hall | | | | | 22e. ADDRESS 615 West Montgomery Avenue, Rockville, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 23b. DATE 12-26-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | |
| 23d. LOCATION (City or Town) Rockville, Montgomery Co., Md. | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | | | | 25a. REC'D BY REGISTRAR DATE DEC 30 1968 | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

17879

RECEIVED

THE NATIONAL BUREAU OF INVESTIGATION

WASHINGTON, D. C.

REPORT OF SPECIAL AGENT IN CHARGE

7

TO THE DIRECTOR, FBI

FROM THE SAC, NEW YORK

SUBJECT: [Illegible]

DATE: [Illegible]

100-100000

100-100000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|-------------------|--|--|--|---|--|--|--|-----------------------------------|--|-----------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) <u>Michael Allen McCluskey</u> | | | | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> <u>Dec. 31</u> 19 <u>68</u> | | | 2b. HOUR <u>10 AM</u> | | |
| 3. SEX <u>M.</u> | 4. RACE <u>W.</u> | 5. DATE OF BIRTH <u>Sept 4, 1961</u> | 6. AGE (In years last birthday) <u>7</u> YRS. <u>3</u> MONTHS <u>27</u> DAYS | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month <u>Dec.</u> Day <u>31</u> Year <u>1968</u> | | | 2d. HOUR <u>11 AM</u> |
| 7a. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Monrovia</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Route 1 Gladhill Rd.</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u> | | | 13b. COUNTY <u>Montgomery</u> | | | 13c. CITY OR TOWN <u>Monrovia</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <u>Route 1 Gladhill Rd.</u> | |
| 14. FATHER'S NAME First <u>Harry</u> Middle <u>McCluskey</u> Last <u></u> | | | | 15. MOTHER'S MAIDEN NAME First <u>Jenna</u> Middle <u></u> Last <u>Lowe</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16b. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT ADDRESS <u>Harry L. McCluskey, Jr. Monrovia, Md.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia - viral</u>
<u>480X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>
(b) <u></u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24h.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>492X</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <u>19</u> P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>Dec. 31, 1968</u> | | | |
| EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Jan. 2, 1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Seals Cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>Etchison, Md.</u> | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>JAN 6 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

15884

RECEIVED 12 JAN 1963
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

15884

JAN 8 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 72 hours after death.

| 17870 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 17881 | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First Middle Last | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | | | | |
| Horace L. McCoy Jr. | | | | Dec. 30, 1968 | | 3P. M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS
HOURS MIN | |
| male | | white | | 11/9/19 | | 49 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Bethesda | | U.S.A. | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | Suburban | | Retarded | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Mont. | | Cherry Chase | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 3802-Wealthiest St. | | | |
| 14. FATHER'S NAME
First Middle Last | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | | | |
| Horace L. McCoy | | Evelyn | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No. | | None | | Evelyn McCoy | | Same as Item 13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | 1579 | | Metastatic Carcinoma | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | Adenocarcinoma, PANCREAS | | | | | | | |
| | | (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 157X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 16, 1968, to Dec 30, 1968, that (I) (we) last saw the deceased alive on Dec 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
W.T. Marcus MD | | DEGREE
MD | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1-2-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Wm. T. Marcus | | 22e. ADDRESS
10620 Georgia Ave. Silver Spring, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Cremation | | 1-3-69 | | Cedar Hill Crematory | | Suitland, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE JAN 6 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

1887

1887

1887

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|---|
| 17871 | | | | | 17882 | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
BERTHA VIOLA Mc Cae | | | | | 2a. DATE OF DEATH Month Day Year
December 7 1968 | | | 2b. HOUR
10:55 P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
10-19-05 | | 6. AGE (In years lost birthday)
63 YRS. | | IF UNDER 1 YEAR MONTHS OAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Mo. | | 7b. CITIZEN OF WHAT COUNTRY?
American | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON SON. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HELPER Inc. Falls Church, VA. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Virginia | | 13b. COUNTY
Falls Church | | 13c. CITY OR TOWN
Falls Church | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7447 Ivywood Rd. | |
| 14. FATHER'S NAME First Middle Last
William FIRTH | | | 15. MOTHER'S MAIDEN NAME First Middle Last
? EDWARDS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
578-54-3199 | | 17. INFORMANT Address
Hospital Records, Takoma Park, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Edema</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma metastatic to the brain (multiple)</u> unknown
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Carcinoma of lower lobe of left lung</u> unknown
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.
<u>1621</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>72 hours</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>163X</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Seruch T. Kimble, M.D. DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12-7-68. | | |
| 22d. PHYSICIAN'S NAME (Type)
Seruch T. Kimble | | | | | 22e. ADDRESS
9801 Georgia Ave, Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12/10/68 | | 23c. NAME OF CEMETERY OR CREMATORY
National Mem. Park | | 23d. LOCATION (City or Town) (County) (State)
Falls Church, Fairfax, Va. | | | |
| 24. FUNERAL DIRECTOR
P. M. Jackson | | | | | 25a. REC'D BY REGISTRAR
Falls Church | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

17882

STATE OF CALIFORNIA

17882

1

DEC 18 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17872

CERTIFICATE OF DEATH

17883

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print)
Paul William McCULLAGH, Jr. | | | First Middle Last | | | 2a. DATE OF DEATH
7 December 1968
Month Day Year | | | 2b. HOUR
11:50 AM | | |
| 3. SEX
Male | | | 4. RACE
Cauc | | | 5. DATE OF BIRTH
7 December 1968 | | | 6. AGE (In years last birthday)
YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Virginia | | | 13b. COUNTY
Arlington | | | 13c. CITY OR TOWN
Arlington | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
1830 Columbia Pike, Apt 510 | | | 14. FATHER'S NAME
Paul William McCULLAGH
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
Donna L. DEMPSTER
First Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
NO | | | 16b. SOCIAL SECURITY NO.
NONE | | | 17. INFORMANT
Paul W. McCULLAGH | | | 1830 Columbia Pike Apt 510
Arlington, Virginia | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis, bilateral compatible with hyaline membrane disease
7761
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
7620 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (x) (this hospital) attended the deceased from 7 December 1968, to 7 December 1968, that (x) (we) last saw the deceased alive on 7 December 1968, and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) did (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
G. P. SCHWARTZ, M. D. | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
9 December 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
G. P. SCHWARTZ, M. D. | | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
12-11-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Summit View Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Guthrie (Logan) Oklahoma | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home
7557 Wisconsin Ave., Bethesda, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 16 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

17883

RECEIVED

THE NATIONAL ARCHIVES

1939

1

DEC 1 8 1939

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 18-22a Film 408 MARYLAND STATE DEPARTMENT OF HEALTH
1-2-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17873

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17884

| | | | | | | | | | | | | | | | |
|---|--|----------------------|--|--|--|--|--|---|--|---|--|--|--|------------------------|--|
| 1. DECEASED-NAME
(Type or Print) <u>McDowell George Joseph McDowell</u> | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>12</u> Day <u>18</u> Year <u>68</u> | | | | 2b. HOUR <u>8:45</u> M | | | | | | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>white</u> | | 5. DATE OF BIRTH <u>1-5-11</u> | | 6. AGE (In years last birthday) <u>57</u> YRS. | | IF UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> | | IF UNDER 24 HRS.
HOURS <u> </u> MIN. <u> </u> | | 2c. DATE PRONOUNCED DEAD
Month <u>12</u> Day <u>18</u> Year <u>68</u> | | 2d. HOUR <u>8:45</u> M | |
| 7a. BIRTHPLACE (State or foreign country) <u>Scotland</u> | | | | 7b. CITIZEN OF WHAT COUNTRY? <u>Amer</u> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> <u>SEPARATED</u> <input checked="" type="checkbox"/> | | | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH <u>Takoma Pk</u> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>San * Hosp</u> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u> </u> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>D.C.</u> | | | | 13b. COUNTY <u> </u> | | | | 13c. CITY OR TOWN <u>N.W. DC</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>243 Rock Creek Church Rd</u> | | | |
| 14. FATHER'S NAME First <u>George</u> Middle <u>McDowell</u> Last <u> </u> | | | | 15. MOTHER'S MAIDEN NAME First <u>Bridgett</u> Middle <u>McGlynn</u> Last <u> </u> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | | | 16b. SOCIAL SECURITY NO. <u> </u> | | | | 17. INFORMANT <u>hosp record</u> | | | | ADDRESS <u> </u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Multiple extreme internal injuries</u>
<u>816.0</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>with exsanguination incurred in</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>auto accident</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>823.4</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u> </u> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u> </u> | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH <u> </u> | | | | 21b. TIME OF INJURY Month, Day, Year <u>10:30 P.M. 12-16 1968</u> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>Deceased, driving alone, lost control of auto which left road, and struck pole.</u> | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Street</u> | | | | 21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u>Wash.</u> County <u>D. C.</u> State <u> </u> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>DEC. 18, 1968</u> | | | | | | | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE <u>Dec. 21, 1968</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Montgomery Co. Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Takoma Funeral Home Inc. J. Arthur Walter</u> | | | | ADDRESS <u>254 Carroll (21 N.W.)</u> | | | | 25a. REC'D BY REGISTRAR <u>DEC 13 1968</u> | | | | 25b. REGISTRAR'S SIGNATURE <u> </u> | | | |

17884

WORLD MEDICAL CENTER

FOR SALE

WORLD MEDICAL CENTER

Good F. 1940

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17874

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17885

| | | | | | | | | |
|---|----------------------|---|---|---|--|---|---|---|
| 1. DECEASED-NAME
(Type or Print) <i>Ruth C. McEwen</i> | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>12-9 1968</i> | | | 2b. HOUR <i>30</i> M | | |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH <i>4/12/96</i> | 6. AGE (In years last birthday) <i>72</i> YRS. | IF UNDER 1 YEAR
MONTHS <i>7</i> DAYS <i>28</i> | IF UNDER 24 HRS.
HOURS <i></i> MIN. <i></i> | 2c. DATE PRONOUNCED DEAD
Month <i>12</i> Day <i>9</i> Year <i>1968</i> | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY <i>Mont. Kensington</i> | | 13c. CITY OR TOWN <i></i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First <i>Michael</i> Middle <i>Joseph</i> Last <i>Corbett</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Maria</i> Middle <i>Tobey</i> Last <i></i> | | | 13e. STREET AND NUMBER <i>3506-Nimitz Rd.</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | 16b. SOCIAL SECURITY NO. <i>217-466 192</i> | | | 17. INFORMANT ADDRESS <i>Daughter - Betty Jane Corbett</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Insufficiency Acute -</i>
<i>4129</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Cardiovascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Arterio Sclerosis Generalized</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Recent -</i>
<i>years</i>
<i>years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>4221 Fracture of Rt. Hip</i> | | | | | | | | |
| 19a. DATE OF OPERATION <i>Nov. 28, 1968</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Nothing of Fract. Rt Hip</i> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year <i>8:00 AM NOV 27 1968</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fell. at home causing Fracture of hip</i> | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i> | | 21f. LOCATION Street or R.F.D. No. <i>3506 Nimitz Rd</i> City or Town <i>Kensington</i> County <i>Montgomery</i> State <i>Md</i> | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | EXAMINER'S NAME (Type) <i>JOHN G. BALL</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <i>Dec 9, 1968</i>
ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i> | | |
| 23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input checked="" type="checkbox"/> | | 23b. DATE <i>12-12-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Ammondale Christian</i> | | 23d. LOCATION (City or Town) <i>BroBeltsville</i> (County) <i>Prince Georges</i> (State) <i>Md.</i> | | |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS <i>7557-Wisconsin Ave., Beth., Md.</i> | | | | 25a. REC'D BY REGISTRAR DATE <i>DEC 16 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |

15888

APR 16 1968

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178865

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17886

| | | | | | | | | | |
|---|--|---|--------|---|--|--|----------------------------|--|---------------------------------|
| 1. DECEASED-NAME
(Type or print) | | First
<i>Samuel</i> | Middle | Last
<i>McKaig</i> | 2a. DATE OF DEATH
Month <i>Dec</i> Day <i>11</i> Year <i>1968</i> | | 2b. HOUR
<i>11:45</i> M | | |
| 3. SEX
<i>male</i> | | 4. RACE
<i>negro</i> | | 5. DATE OF BIRTH
<i>? ? 1881</i> | | 6. AGE (In years last birthday)
<i>87</i> YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS
HOURS
MIN |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S. A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>laborer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>farm.</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md</i> | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Bethesda</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>Rt #2</i> | |
| 14. FATHER'S NAME
First
<i>Joseph</i> | | Middle
<i>McKaig</i> | | Last
<i>Hester</i> | | 15. MOTHER'S MAIDEN NAME
First
<i>Thompson</i> | | Middle
<i>Thompson</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>214-3041397</i> | | 17. INFORMANT
<i>William H. Bland</i> | | Address
<i>401 - State St. - Wash.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary edema and congestion</i>
<i>4270</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>congestive heart failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>4341</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 1</i> , 19 <i>68</i> , to <i>Dec 11</i> , 19 <i>68</i> ; that (I) (we) last saw the deceased alive on <i>Dec 11</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Stewart Clapp M.D.</i> | | DEGREE
<i>M.D.</i> | | ATTENDING PHYS.
<input type="checkbox"/> | | MED. DIRECTOR
<input type="checkbox"/> | | STAFF PHYS.
<input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Stewart Clapp M.D.</i> | | 22e. ADDRESS
<i>5415 W. Cedar Lane Bethesda Md.</i> | | 22c. DATE SIGNED
<i>12-13-68</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>12-18-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Martinsburg Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Martinsburg Montg Md.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Robert L. Snowden</i> | | ADDRESS
<i>Rockville Md</i> | | 25a. RECD BY REGISTRAR
<i>DEC 20 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

14886

CERTIFICATE OF DEATH

STATE OF NEW YORK

1937

(M)

(D)

(U)

(S)

Signature of the deceased

Signature of the informant

1

Dec 1 1937

Stewart Class 100

DEC 10 1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-68
30M REV. 1-68

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 17876 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17887 | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Emma Marie Mc Vearry | | | | | | | | | | 2a. DATE OF DEATH Month Day Year
12 1 68 | | | | | | | | | | 2b. HOUR
11:40 a M | | | | | | | | | | | | | | |
| 3. SEX
Female | | | | | 4. RACE
White | | | | | 5. DATE OF BIRTH
10/30/96 | | | | | 6. AGE (In years last birthday)
72 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
D.C. | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Montgomery Md | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own home | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | | 13b. COUNTY
Montgomery | | | | | 13c. CITY OR TOWN
Silver Spring | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
12804 Matey Road | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Henry G. Wienecke | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Emma -- Becker | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
no -- | | | | | | | | | | 16b. SOCIAL SECURITY NO.
577-48-7913 | | | | | 17. INFORMANT Address
Emma De Simone 12806 Matey Road, S.S., Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Cardiac Insufficiency
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction 48hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Heart Disease at 2 yr. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr. | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug, 1965, to Dec, 1968, that (I) (we) last saw the deceased alive on Dec 1, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
Ralph F. Patten DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
RALPH F. PATTEN 1407 Woodland Parkway | | | | | | | | | | 22c. DATE SIGNED
12/1/68 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE
12-4-1968 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Prince Georges, Maryland | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
M. Andrew Durrall
Warner E. Pumphrey, Inc. | | | | | ADDRESS
Sil. Spr. Md.
8434 Georgia Avenue | | | | | 25a. REC'D BY REGISTRAR
DEC 5 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | |

723-74

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| 17888 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
SENA P. MEDILL | | | | | | 2a. DATE OF DEATH
Month Day Year
12 3 68 | | 2b. HOUR
1:30 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
11-6-87 | | 6. AGE (In years last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
NEB. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery County Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Ind. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
12919 Valleywood Dr. | |
| 14. FATHER'S NAME
First Middle Last
Soren -- Schmidt | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Karen --- Jensen | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
No | | 16b. SOCIAL SECURITY NO.
526-26-8897 | | 17. INFORMANT
Mrs. Charles Kinahan | | Address
Sil. Spr. Md.
12919 Valleywood Dr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(c) Accelerated ARTERIO-SCLEROSIS
4201 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES
3 DAYS
YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cerebral Vascular Accident; Hyperglycemia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>minutes, 1968</u> , to <u>12/3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Harold W. Draper | | | | DEGREE
M.D. | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/3/68 | |
| 22d. PHYSICIAN'S NAME (Type)
HAROLD W. DRAPER | | | | 22e. ADDRESS
9801 GEORGIA AVE, Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
Burial | | 23b. DATE
12-7-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Mountain View Cemetery | | 23d. LOCATION (City or Town) (State)
Rock Springs Sweetwater Wyoming | | | |
| 24. FUNERAL DIRECTOR
C. Glen Carter | | | | ADDRESS
Sil. Spr. Md.
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | 25a. REC'D BY REGISTRAR
DEC 3 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

88871

should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ~~in any event~~, within 72 hours after death.

CERTIFICATE OF DEATH

17889

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(Type or print)
John | | 3. Middle
Bruce | | 5. Last
Mentzer | | 2c. DATE OF DEATH
Month December Day 1 Year 1968 | | 2b. HOUR
1:55 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
1 July 1914 | | 6. AGE (In years
last birthday)
54 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Usual: Contractor | | 12b. KIND OF BUSINESS OR
INDUSTRY
Construction | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Pennsylvania | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Newville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
R. D. # 2 | |
| 14. FATHER'S NAME First
Bruce | | Middle
Mentzer | | Last
Bertha | | 15. MOTHER'S MAIDEN NAME First
Souders | | Middle
Souders | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No
(If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
215-03-2424 | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Progressive Cachexia
2021
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) Mycosis Fungoides
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
8 months
10 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
205X History of coronary artery disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State
1 | | | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from February 7, 1968 , to December 1, 1968 , that (X) (we) last
saw the deceased alive on December 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (A) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ervin Epstein, MD | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2 December 1968 | | | |
| 22d. PHYSICIAN'S
NAME (Type) Ervin H. Epstein, M.D. | | | | 22e. ADDRESS The Clinical Center, National
Institutes of Health, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
12/4/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Prospect Hill | | 23d. LOCATION (City or Town) Uniontown (County) Pa. (State) Pa. | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home | | | | ADDRESS
1331 Rockville
Rockville, Maryland | | 25a. REC'D BY REGISTRAR
DATE DEC 5 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

028851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| <div>17879</div> <div>CERTIFICATE OF DEATH</div> <div>17890</div> | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) ANGELO S. MESSINA | | | | | 2a. DATE OF DEATH
Month Dec Day 2 Year 68 | | | 2b. HOUR
8:30 P M | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
10 JUNE 1911 | | 6. AGE (In years last birthday)
57 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery City Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
INT. TEL. & TEL. | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8508-16th ST. | |
| 14. FATHER'S NAME First Middle Last
CHARLES MESSINA | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ROSE GUGLISI | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
578-05-8396 | | 17. INFORMANT
Hosp Records Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYCARDIAL INFARCTION
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ONE DAY | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1968 , to 12-2, 1968 , that (I) (we) lost the deceased alive on Dec 2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert Kramer | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/2/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT KRAMER | | | | | 22e. ADDRESS
8484-16th St. 88. Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5 DEC. 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BLADENSBURG MD. | | | |
| 24. FUNERAL DIRECTOR
PINARDI FUNERAL HOME INC. | | ADDRESS
7406 GEORGE AVE. N.W. | | 25a. REC'D BY REGISTRAR
DEC 5 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | | | |

17350

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17890 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17891 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------------------|--|--|--|--|---|--|--|--|--|
| 1 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| Harry Norman Miles | | | | | | | | | | December 28 1968 | | | | | 4:50 AM | | | | | | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years lost birthday) | | | | | 7. IF UNDER 1 YEAR MONTHS DAYS | | | | | 8. IF UNDER 24 HRS. HOURS MIN. | | | | |
| Male | | | | | White | | | | | August 27, 1887 | | | | | 81 YRS. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | Md. | | | | | | | | | |
| Maryland | | | | | U.S.A. | | | | | | | | | | Montgomery | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Rockville | | | | | 263 Congressional | | | | | Congressional Courthouse Employee | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | | | | Montgomery | | | | | Rockville | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 263 Congressional Lane | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| Herbert Miles | | | | | Jenny (Unknown) | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | | | | | | | | | | | |
| Yes WW I | | | | | 218-38-8260 | | | | | Wife | | | | | (Above) | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> | | | | | | | | | | | | | | | 6 hours | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>Hypertensive heart disease</u> | | | | | | | | | | | | | | | 20 years | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) <u>Anemia</u> | | | | | | | | | | | | | | | 15 years | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 443 X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION | | | | | City or Town County State | | | | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | Street or R.F.D. No. | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-15, 1968, to 12/28, 1968, that (I) (we) saw the deceased alive on 12-21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| W.G. Hall | | | | | | | | | | | | | | | 12/28/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) William G. Hall | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | 615 West Montgomery Avenue | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | | | 12/31/68 | | | | | Damascus Cemetery | | | | | Damascus Montg. Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Tyson Wheeler Funeral Home | | | | | | | | | | | | | | | 1331 Rockville Pk. JAN 3 1969 | | | | | f Charles Judge | | | | | | | | | |
| Rockville, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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|------------------------|----------------------|-----------|-----------|
| December 28 1988 | Allen | Norman | Barry |
| 81 | August 27, 1987 | White | Wife |
| Montgomery | X | U.S.A. | Maryland |
| 3045 Congressional | 3045 Congressional | Rockville | Rockville |
| 305 Congressional Lane | Montgomery Rockville | Maryland | Maryland |
| Jenny (Unknown) | Wife | Harriet | Harriet |
| (Above) | 418-38-8260 | WM I | WM I |

William G. Bell
 418 East Montgomery Avenue
 Rockville, Maryland
 20850
 418-38-8260
 12/1/88
 Bureau of Census
 17521 Rockville, MD
 17521 Rockville, MD
 17521 Rockville, MD

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|
| 17881 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17892 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Marion W. Milne</i> | | | | | | | | | | 2a. DATE OF DEATH <i>December 26 1948</i> | | | | | | | | | | 2b. HOUR <i>2:55 P.M.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX <i>F</i> | | | | | | | | | | 4. RACE <i>White</i> | | | | | | | | | | 5. DATE OF BIRTH <i>4-30-08</i> | | | | | | | | | | 6. AGE (In years lost birthday) <i>60</i> YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i> | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH <i>Montgomery</i> | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i> | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i> | | | | | | | | | | 13b. COUNTY <i>Mont</i> | | | | | | | | | | 13c. CITY OR TOWN <i>Bethesda</i> | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER <i>8305 Woodhawn</i> | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First <i>Charles</i> Middle <i>Lindo</i> Last <i></i> | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First <i>Anne</i> Middle <i>Stevens</i> Last <i></i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> | | | | | | | | | | 16b. SOCIAL SECURITY NO. <i>577-44-2575</i> | | | | | | | | | | 17. INFORMANT <i>Alexander M. Milne</i> | | | | | | | | | | Address <i>Same as above</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | PART I. DEATH WAS CAUSED BY: | | | | | | | | | | IMMEDIATE CAUSE (a) <i>Calcific aortic stenosis</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>25 yrs</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) <i>Rheumatic fever</i> | | | | | | | | | | <i>25 yrs</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>4/11/48</i> | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ASHD = Myocardial infarct, Remote (1944)</i> | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-9-48</i> to <i>12-26-48</i> , that (I) (we) lost the deceased alive on <i>12-9-48</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Paul D. Cantor</i> | | | | | | | | | | 22c. DATE SIGNED <i>12/27/48</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>PAUL D. CANTOR</i> | | | | | | | | | | 22e. ADDRESS <i>XXXX 4709 Montgomery La. Bethesda, Maryland</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | | | | | | | | | | 23b. DATE <i>12-30-68</i> | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i> | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Md.</i> | | | | | | | | | | 25a. REC'D BY REGISTRAR <i>JAN 2 1969</i> | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

17082

CERTIFICATE OF BIRTH

STATE OF TEXAS, COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this day personally appeared

_____ known to me to be the person whose name is subscribed to the foregoing

instrument, and acknowledged to me that he executed the same for the purposes and

contents therein expressed.

Given under my hand and seal of office this _____ day of _____, 19__.

Notary Public in and for the State of Texas

My Comm. Expires _____ 19__

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
|--|--|---|---|---|---|--|---|-------------------------|--------------------------------------|---|--------|---------|-------|------------------------------------|--|
| 17892 CERTIFICATE OF DEATH 17893 | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR A | | | | | | |
| JOHN ROBERT MOORE, SR. | | | | | | Month 12 Day 24 Year 68 | | | 11:10 | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| MALE | | NEGRO | | 1/24/04 | | 64 YRS. | | MONTHS DAYS | | HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | |
| MARYLAND | | U.S.A. | | | | MONTGOMERY Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | |
| OLNEY | | | MONTGOMERY GENERAL HOSP. | | | TRUCK DRIVER, RETIRED | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | |
| MARYLAND | | | MONTGOMERY | | GAITHERSBURG | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RT#3, QUINCE ORCHARD RD. | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | | |
| JOHN HENRY MOORE | | | HATTIE --- BRANDSON | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | | |
| | | | | | MEDICAL RECORDS | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> | | | | | | | | | | 4 days | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Coronary Thromboses</u> | | | | | | | | | | 4 days | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis of Coronary</u> | | | | | | | | | | ? | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| <u>Gen'l. Arteriosclerosis</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | | State | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u> </u> , to <u>Dec. 24</u> , 19 <u>68</u> , that (I) (we) last
saw the deceased alive on <u>Dec. 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | 22c. DATE SIGNED | |
| <u>Jack Schumacher</u> | | | | | | | | | | | | | | 12-25-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | 22e. ADDRESS | |
| JACK SCHUMACHER, M.D. | | | | | | | | | | | | | | 105 RUSSELL AVE. GAITHERSBURG, MD. | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | | (County) | | (State) | | | |
| Burial | | 12-28-68 | | Poplar Grove Bapt. Church | | | Darnestown | | | Mtd. | | Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| <u>Robert L. Snowden</u> | | | | Rockville, Md. | | | | JAN 3 1968 | | <u>Charles Judge</u> | | | | | |

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OFFICE OF THE SECRETARY

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25 JAN 1914

WASHINGTON

DEPT. OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
PM | |
|--|---------|--|--|---|---|---|--|---|-------------------------------|
| THOMAS P. MORGAN | | | | | DEC. 12 1968 | | | 1040 PM | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN |
| M | White | | 12/27/04 | | 63 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| D.C. | | USA | | | | MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| SILVER SPRING | | | Holy Cross Hosp. | | | PERSONNEL Aide Agric. Dept. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Md. | | | MONT. | | S.S. | | YES | | 12403 FELDON ST. |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| HENRY WILLIAMS MORGAN | | | LOUISE HERR MORGAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give year or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| YES W.W. II | | | 217-44-0035 | | C. BRENT MORGAN 823 S. ROYAL ST. ALEXANDRIA, VIRGINIA | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>massive Right Cerebral Hemorrhage</u>
<u>4329</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Atherosclerosis + Obstruction Right and Left</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Internal Carotid Arteries, Complete</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>331X</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 wk</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN BY PART 1(a)
<u>Atherosclerosis + Partial Obstruction Vertebral Artery</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 1/24/68 + 11/27/68 | | Obstruction Carotid Artery | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> , 19 <u>68</u> , to <u>12/12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Martin D. Xelani MD</u> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>12/13/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Cremation | | 12/15/68 | | Lee's Crematory | | Washington, D.C. | | 20002 | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Lee Funeral Home Washington, D.C. | | | | | DATE DEC 19 1968 | | J. Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|---------|--|------------------|--|--|---------------------------------|--|--|--|----------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| SARAH | | | S. MORRIS | | | Dec 21 1968 | | | 8:45 A M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | |
| Female | | White | | Oct. 2, 1879 | | | 89 YRS. | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Ohio | | | USA | | | | | | Montgomery | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Wheaton | | | Wheaton Nursing Home | | | School Teacher | | | D.E. Schools | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | | Bethesda | | | YES | | | 4800 Bradley Blvd. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | |
| Stephen W. Morris | | | Emma G. Crawford | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes, give year or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | | | |
| No | | | 220-44-3492 | | | Dr. Albert Bright 4809 Broad Brook Rd. | | | Bethesda, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 331X | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital), attended the deceased from <u>Dec 20, 1968</u> , to <u>Dec 21, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | |
| Fred A. Gill, M.D. | | | Dec. 21, 1968 | | | Fred A. Gill | | | 4743 Bradley Blvd., Bethesda, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Cremation | | | Dec. 23, 1968 | | | Cedar Hill Crematory | | | Suitland, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C. | | | DEC 27 1968 | | | j Charles Judge | | | | | | | |

17895



17895

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17885 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17896 | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | |
| First Middle Last
Stephen (n) MORRIS | | | | | | | | | | 8 December 1968 | | | | | | | | | | Month Day Year
1:20A.M. | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Male | | | | | 4. RACE
Cauc | | | | | 5. DATE OF BIRTH
November 13, 1900 | | | | | 6. AGE (In years last birthday)
68 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | | | IF UNDER 24 HRS.
HOURS MIN | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U. S. Army | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Tennessee | | | | | 13b. COUNTY
13c. CITY OR TOWN
Memphis | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
505 S. Perkins | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Lindsey MORRIS | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sara RITTENHOUSE | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) Yes | | | | | | | | | | 16b. SOCIAL SECURITY NO.
16c. COUNTY
16d. STATE
Tennessee | | | | | 17. INFORMANT Address
Ann MORRIS, 505 S. Perkins, Memphis, Tenn. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Carcinoma of the Lung</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 1 December, 1968, to 8 December 1968, that (X) (we) last saw the deceased alive on 8 December 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Ashton Lynel Graybiel | | | | | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
A. L. GRAYBIEL, LCDR MC USN | | | | | | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | | | | | | | | 23b. DATE
12/9/68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
J. WILLIAM LEE'S SONS CO. | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. 20002 | | | | | | | | | |
| 24. FUNERAL DIRECTOR
J. WILLIAM LEE'S SONS CO., | | | | | | | | | | ADDRESS
Fourth & Massachusetts Ave N.E., Washington, D. C. | | | | | | | | | | REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | | | | | | | | | | | | | | | |
| DATE
DEC 12 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

13626

RECEIVED

DEC 15 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17896 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17897 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| GEORGE A. MOSE | | | | | | | | | | DECEMBER 3 1968 | | | | | | | | | | 755A M | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR | | | | | IF UNDER 24 HRS. | | | | |
| MALE | | | | | CAUCASIAN | | | | | APRIL 17, 1914 | | | | | 54 YRS. | | | | | MONTHS | | | | | DAYS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| DIST. OF COLUMBIA | | | | | USA | | | | | | | | | | MONTGOMERY Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| BETHESDA | | | | | NAVAL HOSPITAL | | | | | U.S.N. | | | | | N/A | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| DIST. OF COLUMBIA | | | | | | | | | | WASHINGTON | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | WASHINGTON, D.C. 1739 Q ST., N.W. | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| ROBERT MOSE | | | | | LELIA MEREDITH | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | | | 16b. SOCIAL SECURITY NO. 225-46-5738 | | | | | 17. INFORMANT 12912 ALLERTON LANE Address ORVILLE S. MOSE SILVER SPRINGS, MD. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute gastrointestinal hemorrhage secondary to 569.4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF multiple small bowel ulcerations | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 578x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from NOV. 16, 1968, to DEC. 3, 1968, that (A) (we) last saw the deceased alive on DEC. 3, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE John S. Ratliffe M.D. | | | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED December 4, 1968 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) John S. Ratliffe, M.D. | | | | | | | | | | 22e. ADDRESS Naval Hospital, Bethesda, Md. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | 23b. DATE Dec 6, 1968 | | | | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY | | | | | 23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS FRANCIS GASCH'S SONS, HYATTSVILLE, MD. | | | | | 25a. REC'D BY REGISTRAR DATE DEC 9 1968 | | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please make carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|---|-------------------------------------|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Lisa Anne Moulson | | | | | | 2a. DATE OF DEATH
Month December Day 31 , Year 1968 | | | 2b. HOUR 11:45 PM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
July 3, 1962 | | 6. AGE (In years last birthday)
6 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Child | | | 12b. KIND OF BUSINESS OR INDUSTRY
-- | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Georgia | | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Atlanta | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
310 Lake Placid Drive | | |
| 14. FATHER'S NAME First Robert Middle Lewis Last Moulson | | | | 15. MOTHER'S MAIDEN NAME First Darlene Middle Last Miller | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
No | | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Tracheal obstruction by tumor mass
2040
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute Lymphocytic Leukemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 Hours
9 Months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
2043 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State
31 | | | | | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from December 28, 1968 , to December 31, 1968 , that (I) (we) last saw the deceased alive on December 31, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harmon J. Eyre M.D. DEGREE | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1 January 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Harmon J. Eyre, M. D. | | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | | |
| 23a. FUNERAL CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/2/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Foulton County Georgia | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | 25a. REC'D BY REGISTRAR
JAN 6 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

11888

RECEIVED

DATE: 11/18/55 TIME: 10:00 AM

TO: DIRECTOR, FBI (100-371090) FROM: SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED] (NY 100-100000)

RE: [REDACTED] (NY 100-100000)

DATE: 11/18/55

TO: DIRECTOR, FBI (100-371090) FROM: SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED] (NY 100-100000)

RE: [REDACTED] (NY 100-100000)

DATE: 11/18/55

TO: DIRECTOR, FBI (100-371090) FROM: SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED] (NY 100-100000)

RE: [REDACTED] (NY 100-100000)

DATE: 11/18/55

TO: DIRECTOR, FBI (100-371090) FROM: SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED] (NY 100-100000)

RE: [REDACTED] (NY 100-100000)

DATE: 11/18/55

TO: DIRECTOR, FBI (100-371090) FROM: SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED] (NY 100-100000)

17898

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17899

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Evelyn Anne Muller | | | 2a. DATE OF DEATH
Month Day Year
December 6 1968 | | | 2b. HOUR
8 15
A M | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
November 17, 1926 | | 6. AGE (In years last birthday)
42 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington Sanitarium - Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
House wife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
14608 Woodcrest Drive | | 14. FATHER'S NAME First Middle Last
JESSE James | | 15. MOTHER'S MAIDEN NAME First Middle Last
UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Records - Washington Sanitarium & Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> 746.4 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>PULMONARY ARTERY ANEURYSM</u> 1109.2
(c) <u>CONGENITAL HEART DISEASE - AORTIC</u> YRS.
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>DEFECT</u>
754.3 <u>COLLAGEN DISEASE</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 1963</u> , to <u>DEC. 6, 1968</u> , that (I) (we) lost saw the deceased alive on <u>DEC. 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Albert H. Grollman | | | | 22c. DATE SIGNED
12/5/68 | | 22d. PHYSICIAN'S NAME (Type)
ALBERT H. GROLLMAN | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
12/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Suitland Maryland | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home | | ADDRESS
51 Rockville | | 25a. REC'D BY REGISTRAR
DEC 9 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17889 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17900 | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|--|--|--|-----------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First <i>last</i>
<i>Bernard Myers Jr</i> | | | | | | | | | | 2a. DATE OF DEATH Month <i>Dec</i> Day <i>28</i> Year <i>1968</i> | | | | | | | | | |
| 3. SEX <i>Male</i> | | | 4. RACE <i>White</i> | | | 5. DATE OF BIRTH <i>Feb 8, 1920</i> | | | 6. AGE (In years last birthday) <i>48</i> YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>West Virginia</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Photographer</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Self. photo</i> | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> COUNTY <i>Montgomery</i> | | | | | | 13c. CITY OR TOWN <i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>9935 Silver Brook Dr.</i> | | | | | | | | | |
| 14. FATHER'S NAME First <i>Bernard</i> Middle <i>Myers</i> Last <i>Sen</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Oliver</i> Middle <i>Potter</i> Last <i>is above</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> | | | | 16b. SOCIAL SECURITY NO. <i>410.9</i> | | 17. INFORMANT <i>Yvonne Myers wife of above</i> Address <i>same as above</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i>
410.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <i>atherosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201</i> | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| | | | | | | | | | | | | | | <i>minutes</i> | | | | | |
| | | | | | | | | | | | | | | <i>year</i> | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 7, 1966</i> , to <i>Dec 28, 1968</i> , that (I) (we) last saw the deceased alive on <i>12-28-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Alfred L. Norton</i> M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED <i>Dec 28 1968</i> | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Alfred L. Norton</i> | | | | | | | | 22e. ADDRESS <i>7710 Dwight Dr. Bethesda, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE <i>Dec 31, 1968</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i> | | | | 23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i> | | | | | | | |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Md. 20014</i> | | | | | | | | 25a. REC'D BY REGISTRAR <i>JAN 6 1969</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | |

13000

8

7710 Dwight D. Eisenhower, Md.

Robert A. Fannin, Md.

Robert A. Fannin, Md.

Robert A. Fannin, Md.

Robert A. Fannin, Md.

Robert A. Fannin, Md.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

closed with 2 exp. max. exp. min. 2

MEDICAL CERTIFICATION

1990

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17901

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|-------------------------------------|--|--|--|
| 1. DECEASED NAME
(Type or print) | | First
DAWN | | Middle
R. | | Last
MYERS | | 20. DATE OF DEATH
12 th 2 nd 68 th | | | | 2b. HOUR
9:05A | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
7/3/67 | | | | 6. AGE (In years
lost birthday)
17 mos | | IF UNDER 1 YEAR
MONTHS 17 4 DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Sil. Sprg, | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
minor | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Beltsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11216 Evans Trail, Belts. | | | | | |
| 14. FATHER'S NAME
Kenneth | | First
Middle
Lost
Wayne Myers | | 15. MOTHER'S MAIDEN NAME
Patricia | | | | First
Middle
Lost
Anne Bailey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
none | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
father Kenneth | | Address
11216 Evans Trail Belts Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-respiratory failure
742X DUE TO, OR AS A CONSEQUENCE OF
(b) Multiple Congenital anomalies
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) Hydrocephalus and Meningo-encephalocele | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
7512 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1/68, 19, to 12/2/68, 19, that (I) (we) last saw the deceased alive on 12/1/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Stanley H. Steinberg, M.D. | | | | DEGREE | | 22c. DATE SIGNED
12/2/68 | | 22d. PHYSICIAN'S NAME (Type)
1040 UNIVERSITY BLD. E.
SILVER SPRING MARYLAND | | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify)
Burial | | 23b. DATE
Dec 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Lucian | | | | 23d. LOCATION (City or Town) (County) (State)
Beltsville Md. | | | | | |
| 24. FUNERAL DIRECTOR
H. S. Saffery | | | | ADDRESS
Washington D.C. | | 25a. REC'D BY REGISTRAR
DEC 5 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | | | |

TO THE SECRETARY OF THE INTERIOR, WASHINGTON, D.C.

FROM THE LAND OFFICE, WASHINGTON, D.C.

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

100-100000-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 10

| 17891 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17902 | | |
|--|--|--|--|---|--|---|-------------------------------------|---------------|
| 1. DECEASED-NAME
(Type or print) | | | | First | Middle | Lost | 2a. DATE OF DEATH
Month Day Year | 2b. HOUR
M |
| Louis Hugh Nance | | | | | | | Dec 30 68 | 8:15 |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | 7. UNDECEASED 1 YEAR
MONTHS DAYS | |
| male | Caucasian | | 6/19/1896 | | 72 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Georgia | USA | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Wheaton | University of Maryland | | Procurement Officer Dept. | | Navy | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | Montgomery | | Silver Spring | | | | 2921 Stanton Ave. | |
| 14. FATHER'S NAME | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| John | S. | | Nance | Martha | | Jane | | Green |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| yes | | 215-16-9123 | | Jean Nance 2921 Stanton Avenue, Sil. Spr. Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>
491X DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pneumonia, probably viral</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>5021</u> DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Chronic Bronchitis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>7 days</u>
<u>2 months</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Arteriosclerosis - Senility</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> , 19 <u>61</u> , to <u>Dec 30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Philip E. Jones M.D.</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/30/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Philip E. Jones</u> | | 22e. ADDRESS
<u>800 Pershing Drive Silver Spring, Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<u>2-3-1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Suitland Pr. Geos., Md.</u> | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc.</u> | | ADDRESS
<u>8434 Georgia Avenue</u> | | 25. REC'D BY REGISTRAR
<u>JAN 6 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

11003

11003

11003

CERTIFICATE OF DEATH

17903

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(Type or print) May | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month December Day 7 Year 1968 | | 2b. HOUR
M 10 | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Aug 8, 1884 | | 6. AGE (In years
last birthday)
84 YRS. | | IF UNDER 1 YEAR
MONTHS 8 DAYS 8 | | IF UNDER 24 HRS.
HOURS 8 MIN 0 | |
| 7a. BIRTHPLACE (State or foreign
country) Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Randolph Hills
Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
TAILOR | | 12b. KIND OF BUSINESS OR
INDUSTRY
CLOTHING | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE D.C. | | 13b. CITY OR TOWN
Wheaton | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2900 MILITARY RD. N.W. | | | | | |
| 14. FATHER'S NAME First ALEXANDER Middle NEIDORF Last NEIDORF | | 15. MOTHER'S MAIDEN NAME First FREDA Middle ? Last ? | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO | | 16b. SOCIAL SECURITY NO.
160-10-1134 | | 17. INFORMANT
Harvey NEIDORF Address 2900 MILITARY RD. N.W. WASHINGTON, D.C. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Vascular Accident | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Benign arteriosclerosis | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| Diabetes Mellitus. Arteriosclerosis Heart Disease. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. 19 Month Dec Year 1968
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | 21f. LOCATION Street or R.F.D. No. 9911 City or Town Georgetown County Prince Georges State MD | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 5, 1967 , to Dec 7, 1968 , that (I) (we) lost
saw the deceased alive on 5 Dec 1968 , and that (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Morton White M.D. | | 22c. DATE SIGNED
7 Dec 68 | | 22d. PHYSICIAN'S
NAME (Type) MORTON WHITE, M.D. | | | | | | | |
| 22e. ADDRESS
9911 Georgia Ave Silver Spring | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) BURIAL | | 23b. DATE
12-9-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
NAT'L MEMORIAL PARK | | 23d. LOCATION (City or Town) (County) (State)
FALLS CHURCH VA. | | | | | |
| 24. FUNERAL DIRECTOR
Goldberg Funeral Home | | ADDRESS
4219 Rte 50 N.W. | | 25a. REC'D BY REGISTRAR
DATE DEC 9 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1980

NO. 10 11 340101 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17893 | | | | | | | | | | 17904 | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|----------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | |
| Martha Skinner Newell | | | | | | | | | | Month Day Year | | | | | 7:00A M | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | | | | | |
| female | | | | | white | | | | | 12/8/77 | | | | | 91 YRS. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | |
| New York | | | | | U.S.A. | | | | | | | | | | Montgomery Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Silver Spring | | | | | 11725 Kemp Mill Rd. | | | | | Writer-magazine | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| Maryland | | | | | Montgomery | | | | | Silver Spring | | | | | 11725 Kemp Mill Rd. | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | |
| Lyman Skinner | | | | | Helen Gibbs | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | | | | | | |
| | | | | | 578-34-2206A | | | | | Betty Newell | | | | | 11725 Kemp Mill Rd. Silver Spring, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis | | | | | | | | | | 5 Days | | | | | | | | | | | | | | |
| 4339 | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) Atherosclerosis | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | |
| 332X | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| | | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965 to 12/23/68, that (I) (we) last saw the deceased alive on 20 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | |
| William D. Aud | | | | | | | | | | | | | | | | | | | | 12/23/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| William D. Aud | | | | | | | | | | 9006 Colesville Rd. Silver Spring Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| burial | | | | | 12/26/68 | | | | | Ft. Lincoln Cemetery | | | | | Prince Georges County, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| The S.H. Hines Company | | | | | | | | | | 2901 14th St. N.W. Washington, D.C. | | | | | DATE DEC 26 1968 | | | | | Charles Judge | | | | |

• • •

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17894

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17905

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|--|--|---|--|--|--|--------------------------|--|---|--|------|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | | Month | | Day | | Year | | 2b. HOUR | |
| Albert | | | | | | Newman | | <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year | | 12 | | 10 | | 1968 | | 10:40 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | Month | | Day | | Year | |
| Male | White | 9/13/18 | | 50 YRS. | | MONTHS DAYS | | HOURS MIN. | | 12 | | 10 | | 1968 | | 10:40 PM | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | | | |
| N.Y. | | USA | | | | Montgomery | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Silver Spring | | Holy Cross Hosp. | | Home Improvement Contractor | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | | | | | |
| Md. | | Montgomery | | Sil. Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12605 Atherton Dr. | | Md. | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | | | |
| Jack | | | | | | Newman | | Edna | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| No | | ----- | | 051-10-3781 | | Jan B. Newman | | same as 13 above | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | HOUR A.M. P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. | | | | City or Town County State | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Dec. 10, 1968 | | | | | |
| Belden R. Read, M.D. | | | | ADDRESS (Street, City, Town, or County) | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | | Dec. 12, 1968 | | | | G. W. Cemetery | | | | Hyattsville, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Charles Judge | | | | 4217 Pk. Rd. 2nd | | | | DATE DEC 13 1968 | | | | Charles Judge | | | | | |

20271

13 ABOVE

1495-01-120

Des. 12, 1968 U. S. Pat. 3,460,900

829 61330

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17895

17906

FOR STATE
HEALTH DEPT.

| | | | | | | | | | |
|---|-------------------------|---|--|---|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or Print) Andrew C. Newman | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 14 Year 1968 | | | 2b. HOUR 6:15 AM | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Oct. 22, 1902 | 6. AGE (in years last birthday)
66 YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month 12 Day 14 Year 1968 | | | |
| 7a. BIRTHPLACE (State or foreign country)
Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3010 Dawson Avenue | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3010 Dawson Avenue | |
| 14. FATHER'S NAME
First Alfred B. Middle C. Last Newman | | | 15. MOTHER'S MAIDEN NAME
First Anne Middle J. Last Roach | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16b. SOCIAL SECURITY NO.
526 -03-9816 | | 17. INFORMANT
Mrs. Stella L. Newman | | | | | |
| | | | | ADDRESS
3010 Dawson Avenue S.S. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1991 Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Generalized Carcinomatosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1992 | | | | | | | | | |
| 19a. DATE OF OPERATION
1992 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED
December 15, 1968 | |
| EXAMINER'S NAME (Type)
Belden R. Reap M.D. | | | | ADDRESS (City, town or county)
Princeton, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
12-16-68 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Lincoln Crematory | | 23d. LOCATION (City or Town) (County) (State)
Prince George's Maryland | | | |
| 24. FUNERAL DIRECTOR
M. Andrew Duwall Warner E. Pumphrey Inc. | | | | 25. REC'D BY REGISTRAR
DATE
DEC 19 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNIT 801
FLOOR 801

1750

WEEKLY ELECTIONS - FURNACE OF STATE

1750

| NAME | | ADDRESS | | CITY | | STATE | | COUNTY | | ZIP | |
|----------|--|---------|--|-------|--|-------|--|--------|--|-------|--|
| J. J. J. | | 12345 | | ABC | | DEF | | GHI | | JKL | |
| M. N. O. | | PQR | | STU | | VWX | | YZA | | BCD | |
| E. F. G. | | H I J | | K L M | | N O P | | Q R S | | T U V | |
| W. X. Y. | | Z A B | | C D E | | F G H | | I J K | | L M N | |
| O. P. Q. | | R S T | | U V W | | X Y Z | | A B C | | D E F | |
| G. H. I. | | J K L | | M N O | | P Q R | | S T U | | V W X | |
| Y. Z. A. | | B C D | | E F G | | H I J | | K L M | | N O P | |
| Q. R. S. | | T U V | | W X Y | | Z A B | | C D E | | F G H | |
| I. J. K. | | L M N | | O P Q | | R S T | | U V W | | X Y Z | |
| A. B. C. | | D E F | | G H I | | J K L | | M N O | | P Q R | |
| S. T. U. | | V W X | | Y Z A | | B C D | | E F G | | H I J | |
| K. L. M. | | N O P | | Q R S | | T U V | | W X Y | | Z A B | |
| C. D. E. | | F G H | | I J K | | L M N | | O P Q | | R S T | |
| U. V. W. | | X Y Z | | A B C | | D E F | | G H I | | J K L | |
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| E. F. G. | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17896 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17907 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last
ANDREW M. NEWMAN | | | | | | | | | | Month Day Year
DECEMBER 12, 1968 | | | | | | | | | | 9:55P M | | | | | | | | | |
| 3. SEX
MALE | | | | | 4. RACE
CAUCASIAN | | | | | 5. DATE OF BIRTH
MAY 12, 1899 | | | | | 6. AGE (In years last birthday)
69 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
NEW YORK | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA, MARYLAND | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
NAVAL HOSPITAL | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U. S. NAVY | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
MILITARY | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
MARYLAND | | | | | 13b. CITY OR TOWN
CHARLES | | | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13d. STREET AND NUMBER
TOMPKINSVILLE | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
JOHN F. NEWMAN | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ANNA M. (UNKNOWN) | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war(s) and date of service)
WWI, WWII | | | | | | | | | | 16b. SOCIAL SECURITY NO. (If known)
213-44-6013A | | | | | | | | | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MALIGNANT MELANOMA WITH MULTIPLE METASTASIS
1729
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1909 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from NOV 25, 1968 , to DEC 12, 1968 , that (X) (we) last saw the deceased alive on DEC 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
P. J. Dean | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
13 DEC 1968 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
P. J. DEAN CDR, MC, USN | | | | | 22e. ADDRESS
NAVAL HOSPITAL, BETHESDA, MD. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | | 23b. DATE
12-16-68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEMETERY | | | | | 23d. LOCATION (City or Town) (County) (State)
ARLINGTON, VIRGINIA | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
PUMPHREY FUNERAL HOME | | | | | 24b. ADDRESS
7557 WISCONSIN AVE., BETHESDA, MARYLAND | | | | | 25a. REC'D BY REGISTRAR
DEC 18 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | |

11207

GENERAL INVESTIGATION

DATE: MAY 12, 1968

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [REDACTED]

RE: [REDACTED]

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

FOR STATE
HEALTH. DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|-----------------------------|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) First Middle Last
<i>Rudolph Jackson Nichols</i> | | | | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year
<i>Dec. 29 1968</i> | | | 2b. HOUR
<i>10:40 AM</i> | | |
| 3. SEX
<i>M</i> | | 4. RACE
<i>W.</i> | | 5. DATE OF BIRTH
<i>Feb 10, 1913</i> | | 6. AGE (In years last birthday) MONTHS DAYS
<i>55 YRS. 10 19</i> | | IF UNDER 24 HRS. HOURS MIN.
<i>10 19</i> | | 2c. DATE PRONOUNCED DEAD Month Day Year
<i>Dec 29 1968</i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Alabama</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD</i> | | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Bethesda</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>9400 Rockville Pike</i> | |
| 14. FATHER'S NAME First Middle Last
<i>UNKNOWN</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Mary Acker</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>yes.</i> | | | | 16b. SOCIAL SECURITY NO.
<i>unknown</i> | | 17. INFORMANT
<i>(Brother) Robert Griffin</i> | | ADDRESS
<i>1410 Cypress St. Severn, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction - Acute -</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>cardio-vascular Disease -</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Hours.</i>
<i>years.</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
<i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John G. Ball</i> | | EXAMINER'S NAME (Type)
<i>JOHN G. BALL</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<i>Dec 29, 1968</i> | |
| ADDRESS (Street, city, town, or county)
<i>Bethesda, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | | 23b. DATE
<i>12-31-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Williams Cemetery.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Shelby County, Ala.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Robert A. Pumphrey</i>
<i>7557-Wisconsin Ave., Bethesda, Md.</i> | | | | | | 25a. REC'D BY REGISTRAR
DATE
<i>JAN 9 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

17308

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

THE DEPARTMENT OF HEALTH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

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STATE OF NEW YORK

DEPARTMENT OF HEALTH

STATE OF NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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17898

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17909

| | | | | | | |
|--|-------------------------|--|--|---|---|---|
| 1. DECEASED-NAME
(Type or print) <u>May Eve Nicholson</u> | | | 2a. DATE OF DEATH
Month <u>12</u> Day <u>6</u> Year <u>68</u> | | | 2b. HOUR
<u>3:50</u> PM |
| 3. SEX
<u>Female</u> | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>June 16, 1888</u> | | 6. AGE (In years
lost birth day)
<u>80</u> YRS. | 7. UNDER 1 YEAR
MONTHS
DAYS
HOURS
MIN |
| 7a. BIRTHPLACE (State or foreign
country) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. |
| 10. CITY OR TOWN OF DEATH
<u>Rockville</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <u>Potomac Valley Nursing Home</u> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR
INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE <u>Maryland</u> | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Gaithersburg</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
First <u>Charles W.</u> Middle <u>Ward</u> Last <u>Ward</u> | | 15. MOTHER'S MAIDEN NAME
First <u>Hattie L.</u> Middle <u>Duvall</u> Last <u>Duvall</u> | | 17. INFORMANT
Address
<u>J. Arthur Nicholson, Gaithersburg, Md.</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <u>No</u> | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
<u>J. Arthur Nicholson, Gaithersburg, Md.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intra-Cranial Hemorrhage</u> 3 days
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebro-Arteriosclerosis</u> Years
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Generalized Arteriosclerosis</u> Years
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>331X</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1949</u> , to <u>Dec 6, 1968</u> , that (I) (we) last
saw the deceased alive on <u>Dec 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. <u>350 pm</u> | | | | | | |
| 22b. SIGNATURE
<u>Jack Schumacher</u> | | DEGREE
<u>Jack Schumacher, M.D.</u> | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12-6-68</u> |
| 22d. PHYSICIAN'S
NAME (Type)
<u>Jack Schumacher, M.D.</u> | | 22e. ADDRESS
<u>Gaithersburg, Md.</u> | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>Dec. 9, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Salem Meth.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Cedar Grove, Md.</u> |
| 24. FUNERAL DIRECTOR
ADDRESS
<u>Olin L. Molesworth, Damascus, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 10 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

80271

DEC 10 1963

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|-------------------|---|--|--|------------------------------------|---|--|---|--|--|--|
| <div>17809</div> <div>17910</div> <h2>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</h2> | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) FERMOND A NORRIS | | | | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Dec. 8 1968 | | 2b. HOUR 9:50 M | | | |
| 3. SEX M. | 4. RACE W. | 5. DATE OF BIRTH Sept 8 1904 | 6. AGE (In years last birthday) 64 YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month Dec Day 8 Year 1968 | | 2d. HOUR 10:10 M | | | |
| 7a. BIRTHPLACE (State or foreign country) Mo. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 705 Beall Ave. | | |
| 14. FATHER'S NAME First Henry Middle Norris Last Norris | | | 15. MOTHER'S MAIDEN NAME First Minnie Middle Anders Last Anders | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. yes unknown | | | 17. INFORMANT Minnie Brandau ADDRESS 5701 Wyngate Dr. Bethesda, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
492X IMMEDIATE CAUSE (a) Pulmonary Emphysema
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Bronchial Asthma
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
241X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 12/19/68 | | |
| EXAMINER'S NAME (Type) John G Ball | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-11-68 | | 23c. NAME OF CEMETERY OR CREMATORY Rockville, Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Rockville Mont. Md | | | | |
| 24. FUNERAL DIRECTOR Robert A Pumphrey ADDRESS 7557 Wisconsin Ave Bethesda, Md | | | | | | 25a. RECD BY REGISTRAR DEC 16 1968 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | | | |

13810

822-61-330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) HARRY BERNARD O'DELL | | | 2a. DATE OF DEATH
Month December Day 19 Year 1968 | | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
July 24, 1903 | | 6. AGE (In years last birthday)
65 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Cab Driver Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY
Diamond Cab Co. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
4525 Randolph Road | | 14. FATHER'S NAME First Middle Last
Unknown | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
Yes | | 16b. SOCIAL SECURITY NO.
420-1921 578-28-5720 | | 17. INFORMANT
Mrs. Bark O. O'Dell | | Address 4525 Randolph Rd., Silver Spring Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure
4129
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 4200 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1967 , 19____, to 12-18, 1968 , that (I) (we) last saw the deceased alive on 12-17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
L. I. LEAL, M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/19/68 | |
| 22d. PHYSICIAN'S NAME (Type)
L. I. LEAL, M.D. | | | | 22e. ADDRESS
Medical Center, 108 N. Federal Street, Gaithersburg, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
Dec 21, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Blandford Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Petersburg, Virginia | |
| 24. FUNERAL DIRECTOR
W. W. CHAMBERS CO. | | | | ADDRESS
8655 Georgia Ave Silver Spring, Md. | | 25a. REC'D BY REGISTRAR
DEC 23 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James Judge | | | |

MEDICAL CERTIFICATION

7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

26
16
2

| 17991 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17912 | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|------------------------|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR A | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | Hour Min | | | | | | | | | | | | | | |
| Anthony Paul Oliveri | | | | | | | | | | December 6 1968 | | | | | | | | | | 7:30 M | | | | | | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR | | | | | IF UNDER 24 HRS. | | | | | | | | | |
| Male | | | | | White | | | | | 18 September 1946 | | | | | 22 YRS. | | | | | MONTHS DAYS HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | |
| Washington, DC | | | | | USA | | | | | | | | | | Montgomery | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| Bethesda | | | | | The Clinical Center | | | | | Appren: Electrician | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | 13b. CITY OR TOWN | | | | | 13c. INSIDE CITY LIMITS? | | | | | 13d. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | Seabrook | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 9805 Telegraph Road, Apt 12 | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anthony S. Oliveri | | | | | Laura Swetland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> | | | | | 1966-1967 | | | | | 579-62-1018 | | | | | The Medical Records | | | | | | | | | | The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hepatic Failure</u>
<u>201X</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hodgkin's Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | 3 weeks | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | 1 year | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>201X</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | YES | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | |
| Hour A.M. Month Day Year P.M. | | | | | 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from <u>7 Nov.</u> , 19 <u>68</u> , to <u>6 Dec.</u> , 19 <u>68</u> , that he (we) lost saw the deceased alive on <u>6 December</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) diagnose view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| <u>Peter J. Rosen M.D.</u> | | | | | | | | | | | | | | | 6 December 1968 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| Peter J. Rosen, M.D. | | | | | | | | | | | | | | | The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | Dec 9, 1968 | | | | | Ft Lincoln Cemetery | | | | | Colmar Manor Pro Geo Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| F. Gasch's Sons | | | | | | | | | | | | | | | DEC 9 1968 | | | | | | | | | | <u>Charles Judge</u> | | | | | | | | | |
| Hyattsville, Md. | | | | | | | | | | | | | | | DATE | | | | | | | | | | | | | | | | | | | |

21071

3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| | | | | | |
|---|--|---|-----------------|---|------|
| 179002 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 17913 | |
| 1. DECEASED-NAME
(Type or print) <i>Lena</i> | | | First <i>M.</i> | Middle <i>Oram</i> | Last |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>3-1-1901</i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Pennsylvania</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>U.S. Home</i> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | |
| 14. FATHER'S NAME
<i>UNKNOWN</i> | | 15. MOTHER'S MAIDEN NAME
<i>UNKNOWN</i> | | 16. SOCIAL SECURITY NO.
<i>UNKNOWN</i> | |
| 17. INFORMANT
<i>Rest Home Records</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Thrombosis</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Arteriosclerosis</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 hr</i>
<i>1 hr.</i>
<i>10 yrs</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i>
<i>Subacute Myelitis</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/29/68</i> , 19 <i>68</i> to <i>12/7/68</i> , that (I) (we) lost saw the deceased alive on <i>12/6/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Stephen N. Jones</i> | | 22c. DATE SIGNED
<i>12/7/68</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>Stephen N. Jones, M.D.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>12/10/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parklawn Cemetery</i> | |
| 24. FUNERAL DIRECTOR
<i>Tyson Wheeler Funeral Home</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Rockville Maryland</i> | | 25a. REC'D BY REGISTRAR
<i>DEC 9 1968</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | 25c. ADDRESS
<i>1501 Rockville Rd. Rockville, Md.</i> | | 25d. ADDRESS
<i>1501 Rockville Rd. Rockville, Md.</i> | |

15813

THE STATE OF TEXAS

15813

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FOR STATE
HEALTH DEPT

17903 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17914

| | | | | | | | | | | | |
|--|-----------|--|--|--|--|---|--|---|--|--------------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year | | 2b. HOUR | |
| Grace | | Elizabeth | | Overstreet | | | | OF ESTI-
DEATH MATED <input type="checkbox"/> 12- 6 - 1968 | | 5:30M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| Female | Caucasian | 5-5-1888 | | 80 YRS. | | MONTHS DAYS | | HOURS MIN | | Month 12 Day 6 Year 1968 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | 2d. HOUR | |
| New York | | United States | | | | Montgomery | | | | 5:30M | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Olney | | Brooke Grove Foundation | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | Spring, Maryland | |
| Maryland | | Montgomery | | Silver Spring | | | | 3916 Linden Road, Silver | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| Oliver | | Mann | | | | | | Inez | | Carroll | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | Spring, Maryland | |
| | | | | 577-40-0039 | | Mr. Charles Brown, | | 3916 Linden Road, Silver | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4129 | | | | Acute Coronary Insufficiency | | Arteriosclerotic Heart Disease | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | | | (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 11-3 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury or Part 1 or Part 2 Item 18) | | Dec. 6, 1968 | | Chair at Nursing Home | | 7x left | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | 21f. LOCATION Street or R.F.D. No. City or Town County State Silver Spring, Montgom. Ind. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | | Dec. 6, 1968 | |
| EXAMINER'S NAME (Type) Belden R. Reap M.D. | | Wheaton | | ADDRESS (Street, city, town, or county) | | Wheaton, Mont. Co., Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE 12-9-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS | | 5130 Wisconsin Ave, N.W. Washington, D. C. | | 25a. REC'D BY REGISTRAR DEC 12 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17514

17514
MICHAEL FARMER'S REMOVAL OF DEATH

Grace Elizabeth Overleaf

12-8-12

17-1888

Ken Fort

United States

Clay
Home Grove Foundation

Oliver

1911

1911

17-1888

17-1888

X

X

Beldon R. Resp. M. D.

17-1888

17514
MICHAEL FARMER'S REMOVAL OF DEATH

17514

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1/69

| 17994 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 17915 | |
|--|--|--|--------|--|-------------------|
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH |
| Mose | | J. | Paden | | Month Day Year |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| male | | white | | 10-12-03 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (In years last birthday) | |
| West. Va. | | U.S.A. | | 62 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 9. COUNTY OF DEATH | |
| Bethesda | | Suburban | | Montgomery | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | Montgomery | | Cherry Chase | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| First Middle Last | | First Middle Last | | ACTO | |
| Louis | | Paden | | Anna | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 236-05-8451 | | Bessie Paden | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. DATE OF OPERATION | | 20a. AUTOPSY? | |
| PART 1. DEATH WAS CAUSED BY: | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| IMMEDIATE CAUSE (a) Pulmonary Edema | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 4109 | | | | YES | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) Myocardial Infarction | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) Atherosclerotic Coronary Heart Disease | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 4201 | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. Month Day Year | | (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| (If either, notify medical examiner) | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> | | (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | Street or R.F.D. No. City or Town County State | |
| at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 4</u> , 19 <u>68</u> , to <u>DEC 17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>DEC 17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| P.P. Andrews M.D. | | 12-17-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| P.P. ANDREWS M.D. | | Washington A.C. 20016 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 12-19-1968 | | Oakland Jacob Cem | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| GOLDEN FUNERAL HOME | | DEC 23 1968 | | | |
| ADDRESS | | DATE | | | |
| 4217 9th St N.W. | | | | | |

RECORDS OF DEATH

(M)



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17905

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17916

| | | | | | | | | | | | |
|--|---------|------------------------------|--|--|--|---|---|---|---|--|----------|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| William T. Payne | | | | | | Month Day Year | | | 12-31 1968 11:15 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| M | W | 3/29/48 | 20 YRS. | MONTHS DAYS | | HOURS MIN. | | 12 31 Year 1968 | | | 11:15 AM |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | | |
| Wash. DC | | U.S.A. | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | | | Holy Cross Hosp. | | | STUDENT | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Md. | | | Montgomery | | | Rockville | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | |
| GEORGE F. PAYNE | | | EDYTHE Y. JOHNSON | | | NO | | | 173-38-9395 | | |
| 17. INFORMANT | | | ADDRESS | | | 17. INFORMANT | | | ADDRESS | | |
| Mrs. Edythe Y. Payne, Mother, Same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple Extreme Injuries | | | | | | | | | | | |
| 815.0 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) with Skull Fracture and | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Internal Hemorrhage | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 8194 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | 2300 P.M. 12-31 1968 | | | Deceased, driver thrown from car which struck bridge support | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or town County State | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | Street 495 | | | Silver Spring Beltway Rte. 495 Montgomery Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | |
| Belden R. Reap M.D. | | | | | | Dec. 31, 1968 | | | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (City, town, or county) | | | | | |
| BELDEN R. REAP M.D. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Cremation | | 1/2/69 | | Cedar Hill Crematory | | | Suitland, Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Joseph Gawler's Sons, Inc., Washington, D. C. | | | | | | | | JAN 8 1969 | | Alan M. Jorgensen | |

17516

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY
17516-0000

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY
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RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

179006

CERTIFICATE OF DEATH

17917

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED-NAME
(Type or print) First <i>AGNES</i> Middle <i>PELZER</i> Last | | | 2a. DATE OF DEATH
Month <i>12</i> Day <i>11</i> Year <i>68</i> | | 2b. HOUR
<i>1:30</i> M |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
<i>Sept 22, 1883</i> | | 6. AGE (In years
last birthday) <i>85</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country) <i>MEADZIG, GERMANY</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <i>Potomac Valley Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) <i>HOUSEWIFE</i> | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Md.</i> | 13b. COUNTY
<i>Montg.</i> | 13c. CITY OR TOWN
<i>Bethesda</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>6620 Rannock Rd.</i> | |
| 14. FATHER'S NAME First <i>Peter</i> Middle <i>Rudolf</i> Last | | 15. MOTHER'S MAIDEN NAME First <i>JUNE</i> Middle <i>JOONG</i> Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>241-305832</i> | | 17. INFORMANT
<i>Z. F. Neves</i> Address <i>Beth. Md. 6620 Rannock Rd.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebrovascular Thrombosis</i>
<i>4339</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if only, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <i>Cerebral Arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>8 mos.</i>
<i>5 YRS.</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>332 Chronic urinary tract infection.</i> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1967</i> to <i>12/10/68</i> , that (I) (we) last
saw the deceased alive on <i>12/10/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Henry C. Scruggs</i> | | 22c. DATE SIGNED
<i>12/11/68</i> | 22d. PHYSICIAN'S
NAME (Type) <i>Henry C. Scruggs, M. D.</i> | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
<i>12-13-68</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ethworth M.E. Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Rehobeth Beach Del.</i> |
| 24. FUNERAL DIRECTOR
<i>Robert A Pumphrey</i> | | 25a. ADDRESS
<i>7557 Wisconsin Ave
Bethesda, Md</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | 25c. REC'D BY REGISTRAR
DATE <i>DEC 16 1968</i> |

MEDICAL CERTIFICATION

11881



11881

11881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>Items 1 & 2b Film 4-08</div> <div>1/13/69 kk 17907</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>17918</div> | | | | | | | | | | | | | |
|--|--|-------------------------|--|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) William E. Peters | | | | | | 2a. DATE OF DEATH
Month 12 Day 31 Year 68 | | | 2b. HOUR
10:10 P M | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
12/14/10 | | | 6. AGE (In years last birthday)
58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Electrician | | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-employed | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
10406 Granden Road | | | |
| 14. FATHER'S NAME First Unknown Middle Unknown Last Unknown | | | | 15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | | | 16b. SOCIAL SECURITY NO.
578-03-7708 | | 17. INFORMANT
Mrs. Helen Peters | | | | Address
10406 Gradin Rd. S.S. Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 434.0 Cardio-Pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF Cerebral Embolism, it
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, Arteriosclerosis, generalized
(c) 332x Myocardial infarction, Hypoplasia of kidney | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
sudden
3 days
10 yrs. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1960 , to Dec. 31, 1968 , that (I) (we) last saw the deceased alive on Dec. 31, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Philip H. Varner, M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
1-1-69 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Philip H. Varner, MD | | | | | | 22e. ADDRESS
10620 Georgia Ave., Wheaton, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
Jan. 4, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Rockville Montg. Md. | | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc., | | | | | | 25a. REC'D BY REGISTRAR
Charles Judge | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3

MEDICAL CERTIFICATION

| 179008 DIVISION OF VITAL RECORDS, 501 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17919 | |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) <i>Edna C. Phelps</i> | | | | | | 2a. DATE OF DEATH
Month <i>12</i> Day <i>18</i> Year <i>1968</i> | | | | 2b. HOUR
<i>12</i> M | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W.</i> | | 5. DATE OF BIRTH
<i>6-19-87</i> | | 6. AGE (In years last birthday)
<i>81</i> YRS. | | IF UNDER 1 YR.
MONTHS OAYS HOURS MIN | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Washington DC</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>MONTGOMERY</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Kensington</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Kensington Gardens San</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>AT HOME</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
<i>Kennedy Warden Apt.</i> | | 13b. COUNTY
<i>WASH. DC.</i> | | 13c. CITY OR TOWN
<i>DC.</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>3133 Conn. Ave. N.W. DC.</i> | | | |
| 14. FATHER'S NAME
First <i>Edward C.</i> Middle <i>Schuyler</i> Last <i>Schuyler</i> | | 15. MOTHER'S MAIDEN NAME
First <i>Elizabeth</i> Middle <i>Hassman</i> Last <i>Sgt</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, (no. or unknown) <i>No</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>577-26-9518</i> | | 17. INFORMANT
<i>William C. Phelps</i> Address <i>Sgt</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4369 cerebral vascular accident</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>generalized arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>12 hrs</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>331X Diabetes mellitus</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>January, 1968</i> to <i>Dec 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 17, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> MD DEGREE | | 22c. DATE SIGNED
<i>12/18/68</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>H F Kreuzburg</i> | | 22e. ADDRESS
<i>7852 16 - 4 W Wash DC</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>12-20-1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Glenwood Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Washington, D.C.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Joseph Gawler's Sons, Inc.</i> | | ADDRESS
<i>5130 Wisc. Ave. N.W. Wash. D.C. 20016</i> | | 25a. REC'D BY REGISTRAR
<i>DEC 23 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

17319

STATE OF DEATH

1913

[Faint, illegible text, likely bleed-through from the reverse side of the page]

Washington, D.C.

1913

United States

of the District of Columbia

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17999 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | CERTIFICATE OF DEATH | | 17920 | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print) <i>Vivian EAGAN Pierce</i> | | | | 2a. DATE OF DEATH
Month <i>12</i> - Day <i>28</i> - Year <i>68</i> | | 2b. HOUR <i>8:10 PM</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>1-18-99</i> | | 6. AGE (In years lost-birth day) <i>69</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Tenn.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First <i>Harvey</i> Middle <i>Eagan</i> Last <i>Pierce</i> | | 15. MOTHER'S MAIDEN NAME First <i>Bessie</i> Middle <i>Mullins</i> Last <i>Pierce</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <i>261 40 1073</i> | | 17. INFORMANT Address <i>Betty Flenner - 8213 Job Stuart Rd.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i>
<i>4330</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>332x</i>
(b) <i>CEREBRAL ATHEROSCLEROSIS</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>15 HRS</i>
<i>14 YEAR</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>(ESSENTIAL)</i>
<i>PULMONARY EMPHYSEMA AND CHRONIC ASTHMA. ARTERIAL HYPERTENSION</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>OCT. 9, 1965</i> , to <i>DEC. 28, 1968</i> , that (1) (we) last saw the deceased alive on <i>DEC. 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>James A. Roberts M.D.</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>DEC. 28, 1968</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>JAMES A. ROBERTS</i> | | | | 22e. ADDRESS <i>8907 GEO. AVE. SILVER SPRING, M.D.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | | 23b. DATE <i>12/30/1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Southern Keys Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Key West, Florida</i> | |
| 24. FUNERAL DIRECTOR <i>Jos. Gawler's Sons, Inc</i> | | | | 25a. REC'D BY REGISTRAR <i>JAN 2 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |
| 5130 Wisconsin Ave. N.W. Washington, D.C. | | | | | | | |

11020

RECORD OF DEATH

11020

| | | | |
|------------------------|--|----------------|--|
| Name of Deceased | | Date of Death | |
| John A. Smith | | Jan 15, 1920 | |
| Age | | 35 | |
| Sex | | Male | |
| Race | | White | |
| Marital Status | | Single | |
| Place of Birth | | New York, N.Y. | |
| Cause of Death | | Heart Disease | |
| Time of Death | | 10:30 A.M. | |
| Place of Death | | Home | |
| Signature of Physician | | J. H. Jones | |
| Signature of Registrar | | J. H. Jones | |
| Signature of Witness | | J. H. Jones | |

11020
JAN 15 1920
J. H. Jones
J. H. Jones
J. H. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cared by Dr. Beldon Deep

| | | | | | | | | | | | |
|--|--|--|---|---|----------------------------------|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 17921 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
** Victor Manuel Pina | | | | | | 2a. DATE OF DEATH Month Day Year
12-24-68 | | | 2b. HOUR
1:10 P. M. | | |
| 3. SEX
Male | | 4. RACE
W | | 5. DATE OF BIRTH
12-24-68 8-27-00 | | 6. AGE (In years last birthday)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Cuba | | 7b. CITIZEN OF WHAT COUNTRY?
Cuba | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San & Hosp | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
Takoma Park | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
708 Indlow St. | | |
| 14. FATHER'S NAME First Middle Last
Manuel Victor Pina | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Elenas Huguet Pina | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min
6 min | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1, 1968, to Dec 24, 1968, that (I) (we) last saw the deceased alive on Dec 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
James Whitlock | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12-24-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
James Whitlock | | | | | | 22e. ADDRESS
7717 Cornell Ave Takoma Park Md | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE
12/21/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cem | | 23d. LOCATION (City or Town) (County) (State)
Washington DC | | | | | |
| 24. FUNERAL DIRECTOR
W W Chambers One | | | | | | ADDRESS
8655 Ga Ave Silver Spring Md | | 25a. REC'D BY REGISTRAR
JAN 2 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17911 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17922 | | | | | | | | | |
|---|--|--|------------------------------|--|--|--|--|--|---------------------------------|---|--|-----------------|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| Ilario (NONE) PLACANICA | | | | | | | | | | 12 Month 30 Day 68 Year | | | | | | | | | | 4 15 PM | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| MALE | | | CAUC | | | 5/17/90 | | | 78 YRS. | | | MONTHS | | | DAYS | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| ITALY | | | USA | | | | | | MONTGOMERY Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| TAKOMA PARK | | | | | WASHINGTON SAN. & HOSP. | | | | | CABINET MAKER | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| MARYLAND | | | | | MONTGOMERY | | | | | HYATTSVILLE | | | | | YES | | | | | 2402 Lewisdale Drive | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| Joseph | | | | | PLACANICA | | | | | Carmella Paschetta | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| | | | | | 216-07-2577A | | | | | HOSPITAL RECORDS | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis | | | | | | | | | | | | | | | 1 day | | | | | | | | | | | | | | |
| 4339 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) Generalized Atherosclerosis | | | | | | | | | | | | | | | Several years | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 332x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1963, to Dec 30, 1968, that (I) (we) last saw the deceased alive on Dec 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| Robert B. Irey | | | | | | | | | | MD DEGREE | | | | | 12-30-68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| ROBERT B. IREY | | | | | | | | | | 11161 New Hampshire Ave Silver Spring | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| BURIAL | | | | | 21 JAN 1968 | | | | | GATE 1 | | | | | Horton Wheaton Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| RINALDI FUNERAL HOME | | | | | | | | | | DATE JAN 3 1969 | | | | | | | | | | Charles Judge | | | | | | | | | |
| 7400 Browne Avenue | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17912

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17923

| | | | | | | | | |
|---|----------------------|---|--|--|---|--|-----------------------------------|--|
| 1. DECEASED-NAME
(Type or Print) Harry Plummer | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> Dec 11 1968 | | | 2b. HOUR 2:40 PM | | |
| 3. SEX M | 4. RACE Negro | 5. DATE OF BIRTH Oct 10, 1910 | 6. AGE (in years last birthday) 58 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month Dec Day 11 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) Montg. MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 100 Dawson Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 100 Dawson Ave. |
| 14. FATHER'S NAME First HARRY Middle PLUMMER Last LOTTIE | | | 15. MOTHER'S MAIDEN NAME First SMITH Middle LOTTIE Last SMITH | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | |
| 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Mrs. MAMIE J. BUDI | | | ADDRESS 207 Dawson Ave. Rockville, MD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Coronary Insufficiency Acute -
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardio Vascular Disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) Arterio Sclerosis-Generalized. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden.
years.
years. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 Diabetes Mellitus - | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED Dec 14, 1968 | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 12-16-68 | | 23c. NAME OF CEMETERY OR CREMATORY EMORY GROVE CEM. | | 23d. LOCATION (City or Town) (County) (State) EMORY GROVE, MONTG, MD | | |
| 24. FUNERAL DIRECTOR ROBERT L. SNOWDEN | | | | ADDRESS ROCKVILLE, MARYLAND | | 25a. REC'D. BY REGISTRAR DEC 20 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge |

17533

MEDICAL EXAMINER'S CERTIFICATE IN DEATH

FOR THE
DEPARTMENT OF HEALTH



DEC 20 1968

ROBERT J. SHAW

ROBERT J. SHAW

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|----------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) EMMA | | | First Middle Lost | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| | | | POOLE | | | Dec. 26, 1968 | | | 5 P. M. |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
Nov. 2, 1895 | | 6. AGE (In years last birthday)
73 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| | | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | Md. | |
| 7a. BIRTHPLACE (State or foreign country)
No. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Grosvenor Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Grosvenor Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4325-Maple Ave., Bethesda, Md. | |
| 14. FATHER'S NAME
First Middle Lost
W. W. Peeler | | | 15. MOTHER'S MAIDEN NAME
First Middle Lost
UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO.
246-30-8895 | | 17. INFORMANT Dorothy Seaver Address
4325-Maple Ave., Bethesda, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral thrombosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 weeks. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
331X Hypertensive Arteriosclerotic Heart Disease | | | | | | | | | |
| 19a. DATE OF OPERATION
7/9/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 9, 1968 , to Dec 26, 1968 , that (I) (we) last saw the deceased alive on 12/22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J. Blaine Fitzgerald M.D. | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/27/68. | | |
| 22d. PHYSICIAN'S NAME (Type)
J. BLAINE FITZGERALD | | | | | 22e. ADDRESS
8218 Wisconsin Ave. Bethesda, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
1-2-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Rockville Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville Montg. Md. | | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS
7557-Wisconsin Ave., Bethesda, Md. | | | | | 25a. REC'D BY REGISTRAR
JAN 9 1969
DATE | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

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RECEIVED AT DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 17914 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17925 | | | | | | | | | |
|---|--|--|------------------------------|--|--|--|--|--|---------------------------------|---|--|-----------------|--|--|---|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| Robert William Portch | | | | | | | | | | Month 12 Day 22 Year 68 | | | | | | | | | | 10 P M | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS | | | | | | | | | | | | | | |
| M | | | Caucasian | | | Nov. 25, 1913 | | | 55 YRS. | | | MONTHS | | | DAYS | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Virginia | | | USA | | | | | | Montgomery Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Takoma Park | | | | | Wash. San + Hosp | | | | | Furniture storage | | | | | same | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Ja. | | | | | Fairfax | | | | | Falls Church | | | | | YES | | | | | 1001 madison lane | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| George S. Portch | | | | | Olive Troup | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | Wife 1001 madison lane, Falls Church | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) myocardial infarction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) coronary atherosclerosis + occlusion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | yes | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | | | | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-319-68, to 12-22-19-68, that (I) (we) last saw the deceased alive on 12-22-19-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | | | | | | |
| Boris R. Portch | | | | | | | | | | | | | | | | | | | | 12-23-68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| Boris R. Portch | | | | | | | | | | 1009 Univ Blvd S.S. 50. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 12/26/68 | | | | | National Mem. Park | | | | | Falls Church, Virginia | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Falls Church Funeral Home | | | | | | | | | | | | | | | DATE DEC 27 1968 | | | | | J. Charles Judge | | | | | | | | | |

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VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 17915 | | | | | 17926 | | | | | | |
| 1. DECEASED NAME
(Type or print) First Middle Last
<i>Core S. Porter</i> | | | | | 2a. DATE OF DEATH
Month Day Year
<i>Dec. 19 68</i> | | | 2b. HOUR
<i>4 PM</i> | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>FEB. 17, 1889</i> | | 6. AGE (In years last birthday)
<i>79</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>SOUTH CAROLINA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>MONTGOMERY</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>KENSINGTON</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>CARROLL HALL SANT.</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>SCHOOL TEACHER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>EDUCATION</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD</i> | | 13b. COUNTY
<i>MONTG</i> | | 13c. CITY OR TOWN
<i>BETH.</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>9413 SEVEN LOCAS RD.</i> | | | |
| 14. FATHER'S NAME
First Middle Last
<i>Sam PORTER</i> | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>MARY PORTER</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<i>No</i> | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
<i>249-26-7027</i> | | 17. INFORMANT
Address
<i>MRS NETTIE HOWARD ARLINGTON Va.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Arteriosclerosis.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
<i>4369</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<i>331X None</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>—</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>—</i> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>—</i> | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
<i>19</i> P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
<i>—</i> | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
<i>—</i> | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State
<i>—</i> | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>5/22</i> , 19 <i>68</i> , to <i>present</i> 19 <i>—</i> , that (1) (we) last saw the deceased alive on <i>12/18</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>John B. Umhou</i> M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/19/68</i> | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>JOHN B. UMHOU</i> | | | | | 22e. ADDRESS
<i>8805 Conn. Ave. Chevy Chase, Md.</i> | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>Dec. 22, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Sunrise Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Pickens, Pickens, S.C.</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>Tyson Wheeler F. H.</i> | | | | | 1331 Rockville Pk.
Rockville, Maryland | | 25a. REC'D BY REGISTRAR
DATE <i>DEC 23 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

CHICKEN DISEASES

CHICKEN DISEASES
BY
J. B. HENNING
AND
J. B. HENNING

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | |
|--|--|--|--------|---|-------------------|--|------|---|--|
| Frank Earl Poultter | | | | | Month | Day | Year | 6:50 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | | Caucasian | | February 5, 1900 | | 68 | | YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Pittsburg, Pa. | | USA | | | | Montgomery County | | Construction | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Chevy Chase, Md. | | 5100 Dorset Ave. apt. 507 | | Building Contractor | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Montgomery | | Chevy Chase | | YES | | 5100 Dorset Ave | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Herbert (NMN) Poultter | | Anna (NMN) O'Brien | | YES | | 374-09-866 | | Thema Poultter (wife) 5100 Dorset Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 20. DATE OF OPERATION | | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis with Cachexia
150X
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of the Esophagus
DUE TO, OR AS A CONSEQUENCE OF
(c) | | 2-3 months | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 150X Emphysema | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | 22b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April, 1968, to December 23, 1968, that (I) (we) lost saw the deceased alive on December 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
J. Neill Kennedy, M.D. | | 22c. DATE SIGNED
December 25, 1968 | | 22d. PHYSICIAN'S NAME (Type)
J. Neill Kennedy | | 22e. ADDRESS
916-19th St. N.W., Washington, D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 12-28-68 | | Parklawn Cemetery | | Rockville Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. DATE | | | |
| Joseph Gawler's Sons Inc, Washington, D.C. | | JAN 2 1969 | | Charles Judge | | | | | |

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RECEIVED OF DEPT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|---|---|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 17917 | | | | | | | | | |
| 17928 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Wilhelmine | | | PRADES | | | December | | | Day 5 Year 68 240P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Female | | Caucasian | | August 11, 1928 | | 40 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Germany | | USA | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda | | | Naval Hospital | | | housewife | | | N/A |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| Florida | | | Escambia | | Pensacola | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3305 West Lloyd Street |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Albert Koch | | | Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | | | | Pensacola Address Florida | | | | |
| | | | | | ADRC Albert M. Prades, 3305 W. Lloyd St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) 3969 POST OP. REPLACEMENT OF MITRAL AND AORTIC | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) VALVES | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 410X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1968, to Dec. 5, 1968, that (I) (we) last saw the deceased alive on Dec. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | |
| W. E. BEASLEY, III, M.D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 6 Dec. 1968 | |
| 22d. PHYSICIAN'S NAME (Type) W. E. BEASLEY, III, CDR, MC, USN | | | | | | 22e. ADDRESS | | | |
| | | | | | | Naval Hospital, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Cremation | | 12/7/68 | | J. William Lee's Sons Co. | | Washington | | D.C. | |
| 24. FUNERAL DIRECTOR J. William Lee's Sons Co. | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| 4th and Massachusetts Ave., N.E. Washington, D.C. | | | | | | DEC 11 1968 | | Charles Judge | |

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17918 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17929

| | | | | | | | | | | | |
|---|------------------------|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or Print) Roy | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year Dec. 31 1968 | | 2b. HOUR 12:25 AM | |
| 3. SEX male | 4. RACE wh. tr. | 5. DATE OF BIRTH 1/7/24 | 6. AGE (in years last birthday) 44 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD
Month Dec. Day 31 Year 1968 | | 2d. HOUR 12:25 AM | |
| 7a. BIRTHPLACE (State or foreign country) Georgia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Construction | | 12b. KIND OF BUSINESS OR INDUSTRY Alexander - | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Illinois | | 13b. COUNTY COOK | | 13c. CITY OR TOWN ROSEL | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER R#3. | | | |
| 14. FATHER'S NAME Roy First Middle Last | | | | 15. MOTHER'S MAIDEN NAME Ivie MAE JAMES First Middle Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16b. SOCIAL SECURITY NO. 1941-1943 | | 17. INFORMANT Cherry Raines - wife - odd. name ADDRESS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Coronary Insutsiciency Acute.
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardio Vascular Disease -
DUE TO, OR AS A CONSEQUENCE OF
(c) Years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | EXAMINER'S NAME (Type) John G. Ball | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED Dec. 31, 1968. | |
| ADDRESS (Street, city, town, or county) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) burial | | 23b. DATE 1-2-69 | | 23c. NAME OF CEMETERY OR CREMATORY Aycock Cemetery | | 23d. LOCATION (City or Town) RFD#2 (County) Wayne (State) N. Caroli | | | | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS 7557-Wisconsin Ave., Bethesda, Md. | | | | | | 25a. REC'D BY REGISTRAR JAN 6 1969 | | 25b. REGISTRAR'S SIGNATURE John Charles Judge | | | |

11888

RECEIVED THE FOLLOWING INFORMATION FROM THE
MEDICAL DEPARTMENT, 100th AIRBORNE DIVISION
ON 11/11/50

THIS IS THE
ORIGINAL COPY



11888

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|-------------------------|---|-------------------------------------|---|---|--|--|
| 17919 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17930 | |
| 1. DECEASED-NAME
(Type or print) <u>FRANK</u> | | First | Middle | Last | 2a. DATE OF DEATH
<u>12</u> Month <u>31</u> Day <u>68</u> Year | | 2b. HOUR
<u>10:30</u> M |
| 3. SEX
<u>M.</u> | 4. RACE
<u>Cauc.</u> | | 5. DATE OF BIRTH
<u>3/6/1877</u> | | 6. AGE (In years last birthday)
<u>91</u> YRS. | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS.
DAYS |
| 7a. BIRTHPLACE (State or foreign country)
<u>West-Peabody Mass.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. | |
| 10. CITY OR TOWN OF DEATH
<u>Cherry Chase</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Bethesda-Silver Spring Md.</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>District of Columbia</u> | | 13b. COUNTY
<u>District of Columbia</u> | | 13c. CITY OR TOWN
<u>5315 Conn Ave NW</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
<u>Thomas</u> | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME
<u>Ellen</u> | | First
<u>Syna</u> |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown) <u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>219-03-3868A</u> | | 17. INFORMANT
<u>Self</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
<u>4129</u> IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebro-vascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arteriosclerotic Heart disease</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>1 month</u>
<u>10 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4200</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/28/1968</u> , to <u>12/31/1968</u> , that (I) (we) last saw the deceased alive on <u>12/28/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Edward Adelson, M.D.</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/1/69</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>EDWARD ADELSON, M.D.</u> | | 22e. ADDRESS
<u>7020 Richard Dr. Bethesda Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>Jan. 6, 1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Oak Grove Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Medford Mass.</u> | |
| 24. FUNERAL DIRECTOR
<u>Jos. Gawler Sons</u> | | ADDRESS
<u>5130 Wisc Ave NW Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR
<u>Jan 8 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Gager</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR 41
30 MAY 1968

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|---|--|---|----------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 17920 | | | | | | | | | |
| 17931 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| HENRY JACK REID | | | | | | Month 12 Day 27 Year 68 | | | M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Male | | Negro | | date unknown | | 84 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Charlotte, N.C. | | USA | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Wheaton | | University Nursing Home | | Truck driver | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| D.C. | | Washington | | Wash., DC | | 421 Tea St., NW, Wash., DC | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Lee Ike Reid | | | unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> Army | | | 2410-16-711 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
1621 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchiogenic carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 minutes
6 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1621 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-15-68, 1968, to 12-27, 1968, that (I) (we) last saw the deceased alive on 12-26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>David A. Morowitz, M.D.</u> DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12/27/68 | | |
| 22d. PHYSICIAN'S NAME (Type) David A. Morowitz, M.D. | | | | | 22e. ADDRESS 9237 Three Oaks Dr., Silver Spring, Md. | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE 1-2-68 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| W. H. Bacon | | 3447-14th NW | | | JAN 3 1969 | | [Signature] | | |

17931

STATE OF OHIO

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17921 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17932

| | | | | |
|--|------------------------------|---|---|---|
| 1. DECEASED-NAME
(Type or Print) <i>Josephine E Rencher</i> | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input type="checkbox"/> MONTH Day Year <i>12 18 1968</i> | | 2b. HOUR
<i>8:25 AM</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
<i>3/24/1888</i> | 6. AGE (In years last birthday)
<i>80</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign country)
<i>Iowa</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md</i> | | 13b. COUNTY
<i>Mont</i> | 13c. CITY OR TOWN
<i>Rockville</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
First Middle Last
<i>Frank Etzel</i> | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Baldwine Winkelmann</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Betty L. Ceck Daughter</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>1522</i> <i>INTESTINAL OBSTRUCTION</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Valvulus</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Metastatic Malignant Carcinoma Tumor, ileum.</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>
<i>2 days</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>1527</i> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE
<i>John G. Ball</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<i>Dec 18, 1968</i> |
| EXAMINER'S NAME (Type)
<i>JOHN G. BALL</i> | | ADDRESS (Street, city, town, or county)
<i>Bethesda, Md.</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 23b. DATE
<i>12-20-68</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arlington Natl Cem.</i> | 23d. LOCATION (City or Town) (County) (State)
<i>Arlington, Virginia</i> | |
| 24. FUNERAL DIRECTOR
<i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | 25a. REC'D BY REGISTRAR
DATE <i>DEC 26 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

SEP 51

000 2 8 0 3 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Dr. Keap

MEDICAL CERTIFICATION

| 179322 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17933 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 20. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First
RITA Rose | | | | | | | | | | Middle
xx ROBERTS Robins | | | | | | | | | | Lost
12 25 68 | | | | | | | | | | 8:30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Female | | | | | | | | | | 4. RACE
White | | | | | | | | | | 5. DATE OF BIRTH
2-8-1912 | | | | | | | | | | 6. AGE (In years last birthday)
58 56 YRS. | | | | | | | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Springfield, Ill. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
secretary | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Eli Lilly Co | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Virginia | | | | | | | | | | 13b. CITY OR TOWN
Arlington | | | | | | | | | | 13c. CITY OR TOWN
Arlington | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER
1900 S Eads St. Arlington Va. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
? | | | | | | | | | | Middle
Callahan | | | | | | | | | | Lost
? | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
First
Mary | | | | | | | | | | Middle
? | | | | | | | | | | Lost
O'Neill | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
none | | | | | | | | | | (If yes give war or dates of service)
- | | | | | | | | | | 16b. SOCIAL SECURITY NO.
327-22-1295 | | | | | | | | | | 17. INFORMANT
Mrs. David Jennings | | | | | | | | | | Address
12111 Edgemont | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u>
4360
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>lost.</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
50
Hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
331X | | | | | | | | | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>approx. 1960</u> to <u>the present</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive <u>about 3 weeks</u> prior to (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Adolph Friedman MD</u> | | | | | | | | | | DEGREE
MD | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
12/25/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Adolph Friedman | | | | | | | | | | 22e. ADDRESS
1712 EYE ST. NW, WASH. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | | | | | 23b. DATE
12-28-1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Silver Spr. Montgom. Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
W. Lee Juler
Warner E. Pumphrey, Inc. | | | | | | | | | | ADDRESS
Sil. Spr. Md.
8434 Georgia Avenue | | | | | | | | | | 25a. REC'D BY REGISTRAR
JAN 3 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

12823

Adolph Friedmann
1715 EYE ST NW W 424

Adolph Friedmann

Adolph Friedmann
1715 EYE ST NW W 424

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 408
1-10-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17923

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17934

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|------------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year | | | | 2b. HOUR | | | |
| Frances | | Mariam | | ROE | | | | | | 12 1 1968 | | 5:20A | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | 2d. HOUR | |
| Female | | Caucas | | June 24, 1913 | | 55 YRS. | | | | | | 12 8 1968 | | 5:20A | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | |
| Massachusetts | | | | U. S. | | | | Montgomery | | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | | | Naval Hospital, Bethesda | | | | Secretary | | | | CPA | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Virginia | | | | Falls Church | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 304 E. Broad Street | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | |
| Francis | | Parker | | LOGAN | | | | Eleanor Witham | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | 030-07-0935 | | | | Jack W. ROE, JR., | | | | 304 E. Broad St., Falls Church, Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Overdose of barbiturates & alcohol</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
888.0 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year
3 PM Dec 1 1968 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Took large dose of nembutal when intoxicated | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | | | 21f. LOCATION Street or R.F.D. No.
304 E. Broad St. | | City or Town
Falls Church | | County
Va. | | State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | | | JOHN G BALL MD, MONTGOMERY COUNTY, MD | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
2 DEC 1968 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | |
| Burial | | 12/4/68 | | Arlington National Cemetery, Arlington | | | | Va. | | | | | | | |
| 24. FUNERAL DIRECTOR
Falls Church Funeral 1102 West Broad Street, Falls Church, Va. | | | | | | | | 25a. REC'D BY REGISTRAR
DEC 4 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Jones | | | | | |

15271

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17935 | | | | | |
|--|--|--------------|--|---|--|--|--|--|--------------------------------------|--|--|--|--|---|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last
ABRAHAM Roffenbinder ROTHENBINDER | | | | | | | | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year
Dec. 20, 1968 | | 2b. HOUR <input checked="" type="checkbox"/> PM | | | |
| 3. SEX
Male | | 4. RACE
W | | 5. DATE OF BIRTH
Aug. 14, 1885 | | 6. AGE (In years last birthday) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Month Day Year
December 20, 1968 | | 2d. HOUR <input checked="" type="checkbox"/> PM | |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
solderer | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Jewelry | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Edgemore 4710 Edgemore Lane | | | | | |
| 14. FATHER'S NAME First Middle Last
David Roffenbinder | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Pessie Gitman | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
066-07-6007 | | 17. INFORMANT
Fred Schutzman Bethesda, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 309.6 BRONCHIAL PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) MALNUTRITION
DUE TO, OR AS A CONSEQUENCE OF
(c) SENILE - Atrophy of Brain | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
months
years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
304x | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
JOHN G. BALL, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED
DEC. 21, 1968 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
12-22-68 | | 23c. NAME OF CEMETERY OR CREMATORY
UNITED HEBREW CEMETERY | | | | 23d. LOCATION (City or Town) (County) (State)
STATEN ISLAND, New York | | | | | |
| 24. FUNERAL DIRECTOR
BERNARD DANZANSKY & SONS | | | | 25a. REC'D BY REGISTRAR
DATE DEC 26 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|---|-----------------------|---------|---------------------|--|
| 17925 CERTIFICATE OF DEATH 17936 | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Bo Christian | | Middle
E. | | Last
ROOS | | 2a. DATE OF DEATH
Dec Month 20 Day Year 68 | | 2b. HOUR
M | | | | |
| 3. SEX
Male | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
June 14, 1891 | | | 6. AGE (In years last birthday)
77 YRS. | | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS
HOURS MIN | | | | |
| 7a. BIRTHPLACE (State or foreign country)
California | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 1d. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Virginia | | | 13b. COUNTY
Arlington | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2111 Jefferson Davis Hwy. | | | | | | | |
| 14. FATHER'S NAME
First
Bo Christian | | | Middle
ROOS | | Last
Anna | | 15. MOTHER'S MAIDEN NAME
First
Anna | | | | | Middle
Butt | | Last
Butt | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
Yes | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
505467288 | | 17. INFORMANT
Hospital records | | | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
486X IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
493X | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 26, 1968 , to December 20, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 20, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John R. Fletcher | | | DEGREE
John R. FLETCHER LCDR MC USN | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
21 December 1968 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
John R. FLETCHER LCDR MC USN | | | 22e. ADDRESS | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
12-21-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Lawn | | | 23d. LOCATION (City or Town) (County) (State)
Glendale, California | | | | | | | |
| 24. FUNERAL DIRECTOR
Everly-Wheatley | | | ADDRESS
Funeral Home, Braddock Road, Alexandria, Va. | | | 25a. REC'D BY REGISTRAR
DEC 27 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|--|---------------------------------------|--|--|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 17936 CERTIFICATE OF DEATH 17937 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Terry Lewis Root | | | | | | 2a. DATE OF DEATH Month Day Year
December 28 1968 | | | 2b. HOUR A
11:35 | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
20 June 1958 | | | 6. AGE (In years last birthday) YRS.
10 | | IF UNDER 1 YEAR MONTHS DAYS
10 10 | | IF UNDER 24 HRS. HOURS MIN.
10 10 |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Student | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Pennsylvania | | | 13b. COUNTY
Lancaster | | 13c. CITY OR TOWN
Lancaster | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
722 Fourth Street | | |
| 14. FATHER'S NAME First Middle Last
Walter Root | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Esther Winters | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
No -- | | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Bethesda, Maryland 20014
The Medical Records, The Clinical Center, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia and sepsis
2040
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Lymphocytic Leukemia
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Days
3 Years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
2043 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that 20 (this hospital) attended the deceased from 21 October, 1968 , to 28 Dec. , 19 68 , that (X) (we) last saw the deceased alive on 28 December , 19 68 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Brian W. Goodell M.D. | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
28 December 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Brian W. Goodell, M. D. | | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Dec. 31, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Rawlinsville v. Meth. Cem. | | 23d. LOCATION (City or Town) (County) (State)
Hollywood RD Lancaster Co., Pa. | | | | | |
| 24. FUNERAL DIRECTOR
Carl Reynolds, Jr. Pottsville, Pa. | | | | | | 25a. REC'D BY REGISTRAR
JAN 3 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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John J. Goss

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1961-1962, 1963-1964, 1965-1966, 1967-1968, 1969-1970, 1971-1972, 1973-1974, 1975-1976, 1977-1978, 1979-1980, 1981-1982, 1983-1984, 1985-1986, 1987-1988, 1989-1990, 1991-1992, 1993-1994, 1995-1996, 1997-1998, 1999-2000, 2001-2002, 2003-2004, 2005-2006, 2007-2008, 2009-2010, 2011-2012, 2013-2014, 2015-2016, 2017-2018, 2019-2020, 2021-2022, 2023-2024, 2025-2026, 2027-2028, 2029-2030, 2031-2032, 2033-2034, 2035-2036, 2037-2038, 2039-2040, 2041-2042, 2043-2044, 2045-2046, 2047-2048, 2049-2050, 2051-2052, 2053-2054, 2055-2056, 2057-2058, 2059-2060, 2061-2062, 2063-2064, 2065-2066, 2067-2068, 2069-2070, 2071-2072, 2073-2074, 2075-2076, 2077-2078, 2079-2080, 2081-2082, 2083-2084, 2085-2086, 2087-2088, 2089-2090, 2091-2092, 2093-2094, 2095-2096, 2097-2098, 2099-2100, 2101-2102, 2103-2104, 2105-2106, 2107-2108, 2109-2110, 2111-2112, 2113-2114, 2115-2116, 2117-2118, 2119-2120, 2121-2122, 2123-2124, 2125-2126, 2127-2128, 2129-2130, 2131-2132, 2133-2134, 2135-2136, 2137-2138, 2139-2140, 2141-2142, 2143-2144, 2145-2146, 2147-2148, 2149-2150, 2151-2152, 2153-2154, 2155-2156, 2157-2158, 2159-2160, 2161-2162, 2163-2164, 2165-2166, 2167-2168, 2169-2170, 2171-2172, 2173-2174, 2175-2176, 2177-2178, 2179-2180, 2181-2182, 2183-2184, 2185-2186, 2187-2188, 2189-2190, 2191-2192, 2193-2194, 2195-2196, 2197-2198, 2199-2200, 2201-2202, 2203-2204, 2205-2206, 2207-2208, 2209-2210, 2211-2212, 2213-2214, 2215-2216, 2217-2218, 2219-2220, 2221-2222, 2223-2224, 2225-2226, 2227-2228, 2229-2230, 2231-2232, 2233-2234, 2235-2236, 2237-2238, 2239-2240, 2241-2242, 2243-2244, 2245-2246, 2247-2248, 2249-2250, 2251-2252, 2253-2254, 2255-2256, 2257-2258, 2259-2260, 2261-2262, 2263-2264, 2265-2266, 2267-2268, 2269-2270, 2271-2272, 2273-2274, 2275-2276, 2277-2278, 2279-2280, 2281-2282, 2283-2284, 2285-2286, 2287-2288, 2289-2290, 2291-2292, 2293-2294, 2295-2296, 2297-2298, 2299-2300, 2301-2302, 2303-2304, 2305-2306, 2307-2308, 2309-2310, 2311-2312, 2313-2314, 2315-2316, 2317-2318, 2319-2320, 2321-2322, 2323-2324, 2325-2326, 2327-2328, 2329-2330, 2331-2332, 2333-2334, 2335-2336, 2337-2338, 2339-2340, 2341-2342, 2343-2344, 2345-2346, 2347-2348, 2349-2350, 2351-2352, 2353-2354, 2355-2356, 2357-2358, 2359-2360, 2361-2362, 2363-2364, 2365-2366, 2367-2368, 2369-2370, 2371-2372, 2373-2374, 2375-2376, 2377-2378, 2379-2380, 2381-2382, 2383-2384, 2385-2386, 2387-2388, 2389-2390, 2391-2392, 2393-2394, 2395-2396, 2397-2398, 2399-2400, 2401-2402, 2403-2404, 2405-2406, 2407-2408, 2409-2410, 2411-2412, 2413-2414, 2415-2416, 2417-2418, 2419-2420, 2421-2422, 2423-2424, 2425-2426, 2427-2428, 2429-2430, 2431-2432, 2433-2434, 2435-2436, 2437-2438, 2439-2440, 2441-2442, 2443-2444, 2445-2446, 2447-2448, 2449-2450, 2451-2452, 2453-2454, 2455-2456, 2457-2458, 2459-2460, 2461-2462, 2463-2464, 2465-2466, 2467-2468, 2469-2470, 2471-2472, 2473-2474, 2475-2476, 2477-2478, 2479-2480, 2481-2482, 2483-2484, 2485-2486, 2487-2488, 2489-2490, 2491-2492, 2493-2494, 2495-2496, 2497-2498, 2499-2500, 2501-2502, 2503-2504, 2505-2506, 2507-2508, 2509-2510, 2511-2512, 2513-2514, 2515-2516, 2517-2518, 2519-2520, 2521-2522, 2523-2524, 2525-2526, 2527-2528, 2529-2530, 2531-2532, 2533-2534, 2535-2536, 2537-2538, 2539-2540, 2541-2542, 2543-2544, 2545-2546, 2547-2548, 2549-2550, 2551-2552, 2553-2554, 2555-2556, 2557-2558, 2559-2560, 2561-2562, 2563-2564, 2565-2566, 2567-2568, 2569-2570, 2571-2572, 2573-2574, 2575-2576, 2577-2578, 2579-2580, 2581-2582, 2583-2584, 2585-2586, 2587-2588, 2589-2590, 2591-2592, 2593-2594, 2595-2596, 2597-2598, 2599-2600, 2601-2602, 2603-2604, 2605-2606, 2607-2608, 2609-2610, 2611-2612, 2613-2614, 2615-2616, 2617-2618, 2619-2620, 2621-2622, 2623-2624, 2625-2626, 2627-2628, 2629-2630, 2631-2632, 2633-2634, 2635-2636, 2637-2638, 2639-2640, 2641-2642, 2643-2644, 2645-2646, 2647-2648, 2649-2650, 2651-2652, 2653-2654, 2655-2656, 2657-2658, 2659-2660, 2661-2662, 2663-2664, 2665-2666, 2667-2668, 2669-2670, 2671-2672, 2673-2674, 2675-2676, 2677-2678, 2679-2680, 2681-2682, 2683-2684, 2685-2686, 2687-2688, 2689-2690, 2691-2692, 2693-2694, 2695-2696, 2697-2698, 2699-2700, 2701-2702, 2703-2704, 27

Yes.

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• 50 •

1. The first step is to identify the problem or question that needs to be answered.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|---|---|---|--|----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| David Thomas ROPER | | | | | | Month Day Year
12 1 1968 | | | 2:00 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| Male | | Negroid | | October 26, 1918 | | | 50 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| South Carolina | | U. S. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda | | | Naval Hospital, Bethesda | | | Steward | | | U. S. Navy |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Dist. of Columbia | | | | | Washington | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1624 Portal Drive, N.W. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last
Porcher D. ROPER | | | First Middle Last
Jennie F. FRASIER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| YES | | | 1938-1958 | | Mrs. Florice ROPER Dr., N. W., Wash. D.C. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the colon with widespread metastases</u>
1538 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 1538 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12</u> , 19 <u>68</u> , to <u>Dec. 1</u> , 19 <u>68</u> , that (x) (we) last saw the deceased alive on <u>Dec. 1</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Halbert E. Ashworth, MD</u> | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Dec. 2, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Halbert E. ASHWORTH, M.D. | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 12/5/68 | | Arlington National Cemetery | | | Arlington | | Va. |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Frazier Funeral Home | | | | 389 Rhode Island Ave.
N.W. Washington, D.C. | | DEC 5 1968 | | <u>Charles Judge</u> | |

11558

EXHIBIT A

1. The first part of the document is a list of names and addresses of the persons who have been in contact with the subject of this investigation. The names are listed in alphabetical order, and the addresses are given in full. The list is as follows:

| Name | Address |
|------------------|--|
| Mr. J. A. Smith | 123 Main Street, New York, N. Y. |
| Mr. J. B. Jones | 456 Broadway, New York, N. Y. |
| Mr. C. D. Brown | 789 Third Avenue, New York, N. Y. |
| Mr. E. F. White | 101 West 125th Street, New York, N. Y. |
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| 179328 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17939 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|---|--|------------------------|--|--|---|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| JOSEPH ROSENDORF | | | | | | | | | | 12-25-68 | | | | | | | | | | 12:00 A.M. | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| M | | | W | | | 8-17-92 | | | 76 YRS. | | | MONTHS | | | DAYS | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| POLAND | | | U.S.A. | | | | | | MONTGOMERY | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| SILVER SPRING | | | CHEVY CHASE NURSING & CONVA. CENTER | | | FURRIER | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| D.C. | | | | | | WASHINGTON | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1937 LAMONT ST. N.W. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ABRAHAM | | | ROSENDORF | | | IDA | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | | | | | | | | | | | | | |
| YES | | | W.W.I. | | | 577-48-1563 | | | WIFE Helen Rosendorf | | | 1937 Lamont St N.W. | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 188X PNEUMOPHRIOTIS | | | | | | | | | | 3 MONTHS | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1810 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) CARCINOMA of Urinary Bladder | | | | | | | | | | 2 years | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Arterio-sclerosis - aed C.V.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION | | | | | City or Town County State | | | | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | Street or R.F.D. No. | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July, 1968, to 12/25, 1968, that (I) (we) last saw the deceased alive on 12/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | | | | | | |
| SAMUEL DESSOFF | | | | | | | | | | | | | | | | | | | | 12/25/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| SAMUEL DESSOFF | | | | | | | | | | 1302-18 ST. N.W. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| | | | | | 12-27-68 | | | | | ADAS ISRAEL CEMETERY | | | | | WASH. D.C. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| BERNARD WITZANSKY & SONS | | | | | | | | | | 3501-14 ST. N.W. WASH. D.C. | | | | | DEC 30 1968 | | | | | Charles Judge | | | | | | | | | |

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ROSENBERG

DEC 20 1930

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided on page 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17923

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17940

| | | | | | | | | | | | |
|--|------------------------|---|--|---|--|---|--|--|--|----------------------|----------------------|
| 1. DECEASED-NAME
(Type or Print) Joseph | | First A. | | Middle A. | | Last ROSSELL | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Dec. 14 1968 | | 2b. HOUR 500P | |
| 3. SEX
Male | 4. RACE
Cauc | 5. DATE OF BIRTH
Jul. 25, 82 | | 6. AGE (In years by birthday) 86 | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | | 2c. DATE PRONOUNCED DEAD
Month Dec. Day 14 Year 1968 | | 2d. HOUR 500P |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done during normal working life, even if retired.)
USMC | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before institution) STATE District of Columbia | | | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2101 16th St., N. W. | | | |
| 14. FATHER'S NAME
John Settles Rossell | | | | First John Middle Settles Last Rossell | | 15. MOTHER'S MAIDEN NAME
Sarah McCaffery | | First Sarah Middle McCaffery Last McCaffery | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16b. SOCIAL SECURITY NO.
1901-45 230 40 4167 | | 17. INFORMANT Arlington, Va. ADDRESS Mrs. Florence Tolson, 3422 S. Wakefield | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho Pneumonia Bilateral.
485X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days - | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
491X Fracture of Right Hip | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
7 18 P.M. Nov 13 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Fall in lobby of Hotel where he lived | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Hotel | | 21f. LOCATION Street or R.F.D. No. 2101 16th St. N.W. | | City or Town Washington | | County D.C. | | State D.C. | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED Dec. 16, 1968 | | | |
| EXAMINER'S NAME (Type) John G. Ball, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-18-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery Arlington | | | | 23d. LOCATION (City or Town) (County) (State)
Va. | | | |
| 24. FUNERAL DIRECTOR Everly-Wheatley, 1500 West Braddock Rd. Alexandria, Virginia. | | | | | | 24a. REC'D BY REGISTRAR
DEC 19 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in triplicate by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|---|---|---|--|---|--|
| 179320 | | | | | 17941 | | | | |
| 1. DECEASED-NAME
(Type or print) <u>Fannie</u> | | | First Middle Last <u>Rotkin</u> | | 2a. DATE OF DEATH
Month <u>12</u> Day <u>25</u> Year <u>68</u> | | | 2b. HOUR
<u>12:50 P.M.</u> | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>9/21/76</u> | | 6. AGE (In years
lost birthday) <u>91</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>MONTGOMERY</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<u>SILVER SPRING</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <u>Holy Cross Hosp.</u> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) <u>H.W.</u> | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY
<u>Washington D.C.</u> | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>1125 Spring Rd. N.W.</u> | |
| 14. FATHER'S NAME First Middle Last
<u>Benjamin Rotkin</u> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<u>Sarah Wishnevsky</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT
<u>Benj. Bell Nephew, 9707 Old George Rd. Bethesda, Md.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonitis</u>
<u>486X</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>493X</u> <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-27-68</u> , to <u>12-27-68</u> , that (I) (we) last saw the deceased alive on <u>12-27-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12-25-68</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>ABRAHAM W. DANIS H</u> | | 22e. ADDRESS
<u>1106 SPRING ST. S.S. Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>12/27/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>King David Mem. Garden</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Falls Church, Va.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Bernard Danzansky & Sons</u> | | | | ADDRESS
<u>5501 14th St Wash., D.C.</u> | | 25a. REG'D BY REGISTRAR
DATE <u>DEC 30 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

1784

REPUBLIC OF GUINIA

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0101 Old George Rd
Bethesda, Md.

DEC 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|----------------------------------|---|---|--|---|---|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Simon | | | | First Simon Middle NMI Last Rudman | | | | 2a. DATE OF DEATH
12 Month 16 Day 68 Year | | | 2b. HOUR
2:05 M |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
XXXXXX 5/9/02 | | | 6. AGE (In years last birthday)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
NTONY CTY. Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Healy Cmn | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Salesman | | | 12b. KIND OF BUSINESS OR INDUSTRY
Furniture | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | | 13b. COUNTY
NTONY | | 13c. CITY OR TOWN
S.S. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2312 Colston Drive | | |
| 14. FATHER'S NAME First Ben Middle Rudman Last Rudman | | | | 15. MOTHER'S MAIDEN NAME First Sarah Middle ----- Last ----- | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | | 16b. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Hosp Records - Address ----- | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) NETASTATIC CARCINOMA
1621
DUE TO, OR AS A CONSEQUENCE OF
(b) CARCINOMA LUNG
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) ----- | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
163X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1966 , 19 1966 , to 12-16 , 19 68 , that (I) (we) last saw the deceased alive on DEC -16 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert Kramer MD | | | | DEGREE
MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12-16-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT KRAMER | | | | 22e. ADDRESS
8484 -16th ST. SS. Md 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-17-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Dalton Cem. | | | | 23d. LOCATION (City or Town) (County) (State)
Dalton, Pa. | | | |
| 24. FUNERAL DIRECTOR
Goldberg Funeral Home | | | | ADDRESS
4213 9th St NW Wash. D.C. | | 25a. REC'D BY REGISTRAR
DEC 19 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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DEC 10 1963

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|---|--|---|---|---|---|------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| Mammie | | | None | | | Rumer | | | 7:00 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
| Fe | W. | Jan 1, 1894 | 74 YRS | | | | | Dec 31 1968 | 7:00 PM |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | MD. |
| Gaithersburg | | U.S.A. | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Gaithersburg | | 7932 Muncester Mill Rd | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |
| West Virginia | | | | Egmont | | | | 7 | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Unknown | | | Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | |
| NO | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>
4119
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | | John S. Ball M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
Jan 1, 1969 | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Removal | | 1-1-69 | | Hinkel Funeral Home | | | Davis, West Va. | | |
| 24. FUNERAL DIRECTOR
Robert V. Snowden | | | | ADDRESS
Rockville, Md. | | 25a. REC'D BY REGISTRAR
JAN 6 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

17043

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE
SECRETARY



Approved: 1-1-50 Minister of Agriculture, U.S.A.

Book No. 17043

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|-----------------------------|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--|--|
| 17933 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 17944 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Nettie Peachie Sampson | | | | | | | | | | | | 2a. DATE OF DEATH Month Day Year
Dec 27 1968 | | | | | | | | | | | | 2b. HOUR
5:45 PM | | | | | | | | | | | |
| 3. SEX
Female | | | | 4. RACE
White | | | | 5. DATE OF BIRTH
Dec 15, 1878 | | | | 6. AGE (In years last birthday)
90 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Madison, Va. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Monterey Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 1d. CITY OR TOWN OF DEATH
Winny, Ind. | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Brooke Grove Foundation | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | 13b. COUNTY
Prince George | | | | 13c. CITY OR TOWN
Riversdale | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
4707 Sheridan St. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Henry B Utz | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Rachel G Davis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown
No | | | | 16b. SOCIAL SECURITY NO.
[redacted] | | | | 17. INFORMANT
Nettie Seaman | | | | Address
Riversdale, Ind | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 2509
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260x | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
1 YRS | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1964 to 12/27, 1968, that (I) (we) last saw the deceased alive on 12/27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/27/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
C.H. Ligon MD | | | | 22e. ADDRESS
Sandy Spring, Md. 20860 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
Dec 30, 1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Pro Geo Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
P. Gasch's Sons | | | | ADDRESS
Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
JAN 3 1969 | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | | | | | | | | | | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|--|---|---|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| Fred Harvey Sanders | | | | | | Dec 13, 1968 | | | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| male | white | Dec 20, 1942 | 25 YRS | | | 12 13 Year | | | 68 53 PM |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Md | | U S A | | | | Dec 13, 1968 Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Md Silver Spring | | | Holy Cross Hospital | | | Electrical | | | Engineer |
| 13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
| Md | | | Montgomery | | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 5403 Manorfield Road |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Lawson F Sanders | | | Marjorie Gruver | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS |
| no | | | 214 42 6850 | | | Lawson F. Sanders | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gunshot wound in head, apparently</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>self inflicted</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 976 X <u>Acute severe depression</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | 12-13 19 68 | | Deceased, depressed, shot self in head with pistol | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | Home | | 5403 Manorfield Road Rockville | | Montg. | | Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | | | | |
| BELDEN R. REAP | | | ADDRESS (Street, R.F.D. No., town or county) | | | DEC 14 1968 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Dec 17, 1968 | | George Washington | | Hyattsville Pro Geo Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| F. Gasch's Sons | | | | Hyattsville, Md | | DEC 18 1968 | | Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17925

17946

| | | | | | |
|---|------------------|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
BETTY JO SAWYER | | | 2a. DATE OF DEATH
Month Day Year
Dec 12 2 68 | | 2b. HOUR
140 AM |
| 3. SEX
Female | 4. RACE
White | | 5. DATE OF BIRTH
JULY 13, 1897 | | 6. AGE (In years last birthday)
71 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
OKLAHOMA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Montgomery | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PART. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASH. SAN. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
None | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
BELTSVILLE | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11508 ALLVIEW Drive | | | |
| 14. FATHER'S NAME
First Middle Last
William STANLEY | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Salena JONES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | 16b. SOCIAL SECURITY NO.
445-18-1060 | | 17. INFORMANT
Mrs Dorothy A Beard 11508 Allview Dr, Beltsville | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Atherosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) myocardial infarction
unformed | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 days
1 yr
unformed |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1967, to Dec 2, 1968, that (I) (we) last saw the deceased alive on Dec 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
James W. [Signature] | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12-2-68 | |
| 22d. PHYSICIAN'S NAME (Type)
James W. [Signature] | | 22e. ADDRESS
7717 Canall Ave Takoma Park | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Dec 5, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Spring Creek Mem. Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Oklahoma City, Okla | | | | | |
| 24. FUNERAL DIRECTOR
J Arthur Waltham | | ADDRESS
Sakoma Funeral Home 254 Canale St NW | | 25a. REC'D BY REGISTRAR
DATE DEC 4 1968 | |
| 25b. REGISTRAR'S SIGNATURE
O. [Signature] | | | | | |

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MIDDLE | | | | | | | | | |
|---|--|------------------------------|--|--|--|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 17926 | | | | | | | | | |
| 17947 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| LAWRENCE | | | FADELY SCHILLER | | | Dec. 12 1968 | | | 6 A M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| MALE | | White | | JUNE 27, 1901 | | 67 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| VA. | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Takoma Park | | | WASH & AN Hosp | | | Retired. So RR | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Montgomery | | | Silver Spring | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | Address | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| LAWRENCE F. Schiller | | | Ophelia Harding | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| Confusion | | | 718-10-5823 | | | PATIENTS CHART | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) 191X BRAIN TUMOR, GLIOMA
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE YEAR | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 1930 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 1968, to 20 DEC 1968, that (I) (we) last saw the deceased alive on 12/19/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | |
| Robert H. Meudelrohn, MD | | | 12/20/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| | | | 1015 Spring St Silver Spring Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) |
| Burial | | | Dec 23, 1968 | | | Cedar Hill Cemetery | | | Annapolis Md |
| 24. FUNERAL DIRECTOR | | | 24a. ADDRESS | | | 24b. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE |
| Takoma Funeral Home J. A. Hutton | | | 254 Carroll Ave NE | | | DEC 24 1968 | | | J. Charles Judge |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|
| 17937 | | | | | | | | | |
| 17948 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Stella (Wm) Schmidt | | | | | 2a. DATE OF DEATH
Month Day Year
12 14 1968 | | | 2b. HOUR
2:30 AM | |
| 3. SEX
Female | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
03-14-82 | | 6. AGE (In years last birthday)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Elyria Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Bethesda-Silver Spring Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3304 Shepherd St. | |
| 14. FATHER'S NAME First Middle Last
Adam Schmidt | | 15. MOTHER'S MAIDEN NAME First Middle Last
Johanna Schmidt | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)
No | | 16b. SOCIAL SECURITY NO.
278-22-7777 | | 17. INFORMANT (Name)
Mrs. Betty Lersch | | Address
3304 Shepherd St. Chevy Chase | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4379 ARTERIOSCLEROTIC CEREbrovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 334X
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
NECROSIS OF Bone + Tissues Due to Decubitus Ulcers | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-30, 1968, to 12-14, 1968, that (I) (we) last saw the deceased alive on 12-14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Richard H. Pollen MD | | 22c. DATE SIGNED
12/14/68 | | 22d. PHYSICIAN'S NAME (Type)
RICHARD H. POLLEN, MD | | 22e. ADDRESS
10400 CONNECTICUT AVE, KENSINGTON, MD 20795 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY
KIDGELMAN Cemetery | | 23d. LOCATION (City or Town) (County) (State)
ELYRIA, LORAIN, OHIO | | | |
| 24. FUNERAL DIRECTOR
JOSEPH GAULER'S SONS, INC. WASH., D.C. | | 25a. REC'D BY REGISTRAR
DATE DEC 19 1968 | | 25b. REGISTRAR'S SIGNATURE
j Charles Judge | | | | | |

MEDICAL CERTIFICATION

02851

1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766

8321 84 330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1-69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|---|---|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 17938 CERTIFICATE OF DEATH 17949 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Gertrude C. Scrivenner | | | 2a. DATE OF DEATH
Month Day Year
December 25 1968 | | | 2b. HOUR
9:30 PM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Sept 21, 1879 | | 6. AGE (In years last birthday)
88 89 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Carroll Hall San. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
House wife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3906 Knowles Avenue | |
| 14. FATHER'S NAME First Middle Last
Samuel F. Terwilliger | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ella M. Patrick | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO.
220-44-2950 | | 17. INFORMANT
Address Kensington, Md.
Mrs. Justin Farrell 3915 Baltimore Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chelmonan Elevation</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Failure</u>
(c) <u>Coronary Heart Disease</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours
2 weeks
? | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4200 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1968, to present, 1968, that (I) (we) last saw the deceased alive on Dec 25 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
George Sharpe M.D. | | | | DEGREE
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
December 25, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
George Sharpe, M.D. | | | | 22e. ADDRESS
10400 Connecticut Avenue, Kensington, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-30-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem. | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | | | | |
| 24. FUNERAL DIRECTOR
J. W. Lee Jones
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | ADDRESS
Sil. Spr., Md. | | 25a. REC'D BY REGISTRAR
JAN 3 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 17933 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17950 | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Edward J. Scroggins | | | | | | 2a. DATE OF DEATH Month Day Year Dec. 1 1968 | | 2b. HOUR P. M. 12:50 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 21 June 1931 | | 6. AGE (in years lost birthday) 37 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Mont. Co. Md. | | | |
| 10. CITY OR TOWN OF DEATH Sil. Spg. Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Asbestos Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Chair Engr. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Mont. Co. | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 507 Castelford Dr. | |
| 14. FATHER'S NAME First Middle Last EDWARD J. SCROGGINS | | 15. MOTHER'S MAIDEN NAME First Middle Last NAOMA GRIFFITH | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO | | | | | |
| 16b. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT Address JUNEM SCROGGINS WIFE SILVER SPRING MD. 1880 LYTONSVILLE RD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 400.1 Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Uremia
DUE TO, OR AS A CONSEQUENCE OF (c) Inadequate Hypertension & azotemia.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 441X
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Congestive Heart Failure. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
min. days | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 13, 1968, to Dec 1, 1968, that (I) (we) last saw the deceased alive on November 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Harold W. Draper M.D. DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Dec 1, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D. | | 22e. ADDRESS 9801 GEORGIA AVE, Silver Spring. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Specified | | 23b. DATE 12-4-68 | | 23c. NAME OF CEMETERY OR CREMATORY 7th Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Bladensburg Md. | | | |
| 24. FUNERAL DIRECTOR W.D. Chambers - 1400 - Chapin - N.A. | | ADDRESS Wash. D.C. | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE Charles J. ... | | | |
| DATE DEC 1 1968 | | | | | | | | | |

17820

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|-----------------------------------|
| 17940 CERTIFICATE OF DEATH 17951 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
WILLIAM | Middle
HENRY | Last
SEAQUIST | 2a. DATE OF DEATH
Month 12 Day 25 Year 68 | | | 2b. HOUR
8:21 P |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
10-15-93 | | 6. AGE (In years last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired mechanical Engr. | | 12b. KIND OF BUSINESS OR INDUSTRY
Gov't. | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Olney | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Sharon Nursing Home
18201 Marden Lane | |
| 14. FATHER'S NAME
First Andrew | | | Middle Seaquist | | Last Seaquist | | 15. MOTHER'S MAIDEN NAME
First Hannah
Middle Johnson
Last Johnson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Admission Recd., Montgomery Gen. Hospital, Olney, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
410.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201
(b) ASCVD & aortic insuff. and angina pectoris 5 yrs.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Carcinoma of prostate | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1964 , 19____, to Dec. 25, 1968 , that (I) (we) saw the deceased alive on 12-10-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Frederick Moomau, M.D. | | | | | 22c. DATE SIGNED
12-25-68 | | 22d. PHYSICIAN'S NAME (Type)
Frederick Moomau, M.D. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
12-28-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION (City or Town) (County) (State)
Suitland Md. | | | |
| 24. FUNERAL DIRECTOR
Ernest C. Gartin | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 30 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

17931

DEC 30 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|-----------------------------------|--|--|-----------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Robert | | | Middle
J. | | | Last
Seas | | | 2a. DATE OF DEATH
Month 12 Day 4 Year 68 | | | 2b. HOUR
6:30 PM | | | | | |
| 3. SEX
male | | | 4. RACE
white | | | 5. DATE OF BIRTH
8/24/1906 | | | 6. AGE (In years last birthday)
62 YRS. | | | IF UNDER 1 YEAR
MONTHS
DAYS | | | IF UNDER 24 HRS.
HOURS
MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Ohio | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery
Prince-Georges Md. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver
Adelphia
Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Home
Colonial Villa Nursing Exec. C.I.T. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY
Finance Co. | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Prince
Adelphi
Georges | | | 13c. CITY OR TOWN
Adelphi | | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | 13e. STREET AND NUMBER
1818 Metzert Rd. | | | | | | | | |
| 14. FATHER'S NAME
First
unobtainable | | | Middle
unobtainable | | | Last
unobtainable | | | 15. MOTHER'S MAIDEN NAME
First
unobtainable | | | | | | Middle
unobtainable | | | Last
unobtainable | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
284-10-0559 | | | 17. INFORMANT
Address
Mrs. Robert Seas (same as above) | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral negative septicaemia
5990
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Urinary tract infection
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
609x Parkinson's disease | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1 , 19 68 , to Dec 4 , 19 68 , that (I) (we) last saw the deceased alive on Dec 2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Jeanne Y. Bendler M.D. | | | DEGREE
B.S. | | | ATTENDING PHYS.
<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
12/4/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Benne G. Bendler, M.D. | | | 22e. ADDRESS
4511 W.Va. Avenue-Bethesda, Md. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
12/7/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Prince Georges Co. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
The S.H. Hines Co. Washington, D.C. | | | 25a. REC'D BY REGISTRAR
DEC 7 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | |

8/25/1960

white

male

Ohio

Silver

Warland

unobtainable

081-1-0000

James H. Hendon, M.D.

English

12/3/60

The S. Hines Co., Washington, D. C.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17912 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17953 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|------------------|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last
Miriam Seligman | | | | | | | | | | Month Day Year
December 20 1968 | | | | | | | | | | 11:30 P.M. | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| Female | | | White | | | September 12, 1893 | | | 75 YRS. | | | MONTHS DAYS HOURS MIN. | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Russia | | | U.S.A. | | | | | | Montgomery County Silver Spring Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| Silver Spring | | | Holy Cross Hospital of Silver Spring | | | (Housewife) Cashier | | | Restaurant | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| Maryland | | | Montgomery | | | Rockville | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13000 Pacific Avenue | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| Jacob Katz | | | | | Brina | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | Mildred H. LEFF - 7509 Polce Drive, Annapolis, Virginia | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute left ventricular failure | | | | | | | | | | 3 hours | | | | | | | | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Arteriosclerotic heart disease | | | | | | | | | | years | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes mellitus; arteriosclerotic renal disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May, 1958, to 12-20, 1968, that (I) (we) last saw the deceased alive on 12-20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| Jason Gerber, M.D. | | | | | | | | | | | | | | | 12-20-68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | |
| JASON GERBER, M.D. | | | | | 800 PERSHING DRIVE SILVER SPRING, MD. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | |
| Burial | | | 12-22-68 | | | Bnai Israel Cemetery | | | Norfolk, Virginia | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Bernard Danzansky & Sons | | | | | | | | | | 3501 14th Street, N.W. Washington, D.C. 20010 | | | | | | | | | | DATE DEC 26 1968 J Charles Judge | | | | | | | | | |

13553

STATE OF OHIO

IN SENATE,
January 1, 1901.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1899.
COLUMBUS:
THE STATE PRINTING OFFICE,
1901.

RECEIVED
JAN 1 1901
OFFICE OF THE
COMMISSIONER OF THE
LAND OFFICE
COLUMBUS, OHIO

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|--|--|--|--|--|--|---|---|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR P |
| Lawrence Ellsworth Shinn | | | | | | December 11 1968 | | | 5:30 M |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Male | White | | 11/19/10 | | | 58 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Ohio | | | U.S.A. | | | | | Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Olney | | | Montgomery General | | | Bacteriologist | | | Gov't. |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Howard | | | Clarksville | | Clarksville Ridge | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Charles W. Shinn | | | Mabel Ellsworth | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) If yes give war or dates of service | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| yes | | | 216-44-7734 | | | Montgomery General Hospital, Olney, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> <i>hours</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Post Operative Laparotomy & Colostomy</i> <i>1 week</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Intestinal Obstruction & Carcinoma</i> <i>4 weeks</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Peritonitis, acute</i> | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | |
| 12-4-68 | | | Intestinal Obstruction | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/11</i> , 19 <i>66</i> , to <i>12/11</i> , 19 <i>66</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>12/11</i> 19 <i>66</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (<i>we</i>) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | |
| <i>Charles S. Whitaker, M.D.</i> | | | <i>12/13/68</i> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| Charles S. Whitaker, M. D. | | | Clarksville, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) |
| <i>Cremation</i> | | | <i>11-13-68</i> | | | <i>Lee Funeral Home</i> | | | <i>Washington D.C.</i> |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <i>Higginbottom-Slack</i> | | | <i>Ellwood City, Pa.</i> | | | DATE <i>DEC 16 1968</i> | | <i>Charles Judge</i> | |

13881

8001

1940-1941

| Name | | Address | | Occupation | | Remarks | |
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17955

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | | | |
|--|---------|------------------|--|--|------|--|-----|---|---|---|--|--|-----|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | | |
| James Theodore Simms | | | | | | Month Day Year | | | | 12 14 1968 | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | | |
| M. | Negro | Nov. 25, 1925 | 43 YRS | MONTHS | DAYS | HOURS | MIN | Month Day Year | | | | 14 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | Md. | |
| Virginia | | | U.S.A. | | | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | | Suburban | | | Truck Driver | | | Hauling | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | |
| Md. | | | Montgomery | | | Rockville | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 303 N. Adams St. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| John S | | | Gertrude | | | Yes | | | 1942-46 | | | Brother Leroy Simms - Rt 2, Knoxville | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary Infarction Acute | | | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | years | | |
| (b) Cardio Vascular Disease | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 4221 Fatty Metamorphosis of Liver | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | Hour A.M. P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | Dec 15, 1968 | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| REMOVAL | | | | 12-17-68 | | BROWN FUNERAL HOME | | | | LOVETTSVILLE VA | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| ROBERT L. SNOWDEN | | | | | | ROCKVILLE, MARYLAND | | DEC 20 1968 | | J Charles Judge | | | | |

17332

UNITED STATES DEPARTMENT OF AGRICULTURE

17332

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17945 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17956 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | HOURS MIN. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MAY LOIS SMITH | | | | | | | | | | 12 5 68 | | | | | | | | | | 209 M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| Female | | | | | | | | | | White | | | | | | | | | | January 27, 1908 | | | | | | | | | | 60 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Missouri | | | | | | | | | | United States | | | | | | | | | | | | | | | | | | | | Montgomery | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Silver Spring | | | | | | | | | | 13490 Old Columbia Pike | | | | | | | | | | Clerk | | | | | | | | | | U.S. Army | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Missouri | | | | | | | | | | Miller | | | | | | | | | | Sherris | | | | | | | | | | YES | | | | | | | | | | Star Route | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wooden Arthur Petree | | | | | | | | | | Bernice Henry Petree | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| no | | | | | | | | | | 491-09-7054 | | | | | | | | | | Ann Petree | | | | | | | | | | 13490 Old Columbia Pike Silver Spring, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | 157.9 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | (b) | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 157X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June, 1968, to Dec, 1968, that (I) (we) last saw the deceased alive on Dec 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bernard A. Fitzgerald | | | | | | | | | | 12-5-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BERNARD A. FITZGERALD | | | | | | | | | | 217 UNIV. BLVD E, SILVER SPRING MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | Dec. 8, 1968 | | | | | | | | | | Bethany Cemetery | | | | | | | | | | Pulaski County, Missouri | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Arthur Walters | | | | | | | | | | 254 Cornell Street Wash. DC | | | | | | | | | | DEC 9 1968 | | | | | | | | | | Richard Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

17558

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, NEW YORK STATE, ALBANY, NEW YORK

| | | | |
|------------------------|--|------------------------|--|
| Name of Deceased | | Date of Death | |
| Place of Birth | | Date of Birth | |
| Sex | | Race | |
| Marital Status | | Cause of Death | |
| Occupation | | Place of Death | |
| Signature of Physician | | Signature of Registrar | |
| Date of Certificate | | Place of Death | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 408 Maryland State Department of Health 1-2-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17946

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17957

| | | | | | | | | | | | | | | | |
|--|--|--------------------------------|--|---|--|--|--|---|---|---|--|---|--|----------------------------------|--|
| 1. DECEASED-NAME
(Type or Print)
MARGARET | | First
Garland | | Middle
XXXXXX | | Last
SNODDY | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 12 18 1968 | | | | 2b. HOUR
M | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
May 14, 1918 | | 6. AGE (in years last birthday)
50 YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | | 2c. DATE PRONOUNCED DEAD
Month Dec Day 18 Year 68 | | 2d. HOUR
7:15 M | |
| 7a. BIRTHPLACE (State or foreign country)
Washington, DC | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | | | | Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
9016 Walden Rd. S.S. Md. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
9016 Walden Rd. | | | | | |
| 14. FATHER'S NAME
First George Middle W. Last Garland | | | | 15. MOTHER'S MAIDEN NAME
First Louise Middle -- Last Brown | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | | 16b. SOCIAL SECURITY NO.
578-09-5057 | | 17. INFORMANT Junius L. Snoddy ADDRESS Maryland | | | | 9016 Walden Road, Sil Spr | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 481 x Acute lobar pneumonia,
DUE TO, OR AS A CONSEQUENCE OF
upper lobe, right lung
(b) 490 x
DUE TO, OR AS A CONSEQUENCE OF
(c) 490 x | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Keap | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
DEC. 18, 1968 | | | | | | | |
| EXAMINER'S NAME (Type)
BELODEN R. KEAP, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (City, town, or county)
Sil. Spr., Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-21-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Prince Georges, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | | | C. Glen Carter ADDRESS Sil. Spr., Md. | | | | 25a. REC'D BY REGISTRAR
DEC 23 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

17951

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES
NATIONAL SURVEILLANCE CENTER

17951

17951

17951

17951

17951

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17951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

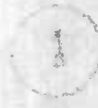
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|---|---|--|--|--|---|--|--|
| 17947 CERTIFICATE OF DEATH 17958 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Dora E. Snyder | | | 2a. DATE OF DEATH Month Day Year
Dec 8 1968 | | | 2b. HOUR
10 A. M. | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
April 11, 1884 | | 6. AGE (In years last birthday)
84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Nebraska | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
10014 Renfrew Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Sp. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
10014 Renfrew Road | |
| 14. FATHER'S NAME First Middle Last
Mark Prime | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Alice Freed | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
508-26-0028 | | 17. INFORMANT
Miss Harriet L. Snyder 10014 Renfrew Rd. Silver Spring, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>Minor Stroke and Cardiac Failure</u>
4379 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral + Cardiac arteriosclerosis</u>
24 years
(c) <u>Generalized Arteriosclerosis</u>
20 + years | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hours | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
334X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 25, 1968, to Dec 8, 1968, that (I) (we) last saw the deceased alive on Dec 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
R. Stephen Hulburt, MD. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Dec 9, 1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
R. Stephen Hulburt | | | | 22e. ADDRESS
3000 Dent Place, N. W., Wash., D. C. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
Dec 10, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | | | |
| 24. FUNERAL DIRECTOR
C. Glen Carter, 433 Georgia Ave.
Warner C. Pumphrey, Inc. Silver Spring, Md. | | | | 25a. REC'D BY REGISTRAR
DEC 12 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

17528

STATE OF TEXAS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|--|--|--|--|--|------------------------------------|---|---|---|---|--|--------------------------------|------------------------|--|
| Item 23 Film 408 1/6/69 kk | | | | | CERTIFICATE OF DEATH | | | | | 17959 | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | | |
| Dewey | | | Miles | | Sparks | | DEC. Month 24 Day 1968 Year | | | 2b. HOUR
3:50 A M | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | | | White | | | Jan 22, 1905 | | | 63 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md | |
| S.C. | | | U.S. | | | | | | Montgomery | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Bethesda | | | Suburban | | | Meat Cutter | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | |
| Md. | | | Montgomery | | | Bethesda | | | | | | 6415 Camrose Terrace | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | |
| George W. Sparks | | | | | Minnie Cash | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | |
| | | | | | 577 09 4843 | | | | | George Sparks 795 Princeton Pl. Rockville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL INFARCTION | | | | | | | | | | 5 DAYS | | | |
| 4330 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 332X (b) CEREBRAL ATHEROSCLEROSIS | | | | | | | | | | 7 YEARS | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ATHEROSCLEROSIS | | | | | | | | | | 7 YEARS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| HYPERTENSION, ESSENTIAL | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from APRIL 21, 1953, to DEC. 24, 1968, that (I) (we) lost saw the deceased alive on DEC. 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Robert G. Angle M.D. | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | | DEC. 24, 1968 | | | |
| Robert G. Angle MD. | | | | | | | | 6009 DELRAY AVE BETHESDA | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial - Transit | | | 12/27/68 | | Oakland Cemetery | | | Gaffney South Carolina | | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler F.H. 1331 Rockville Pike
Rockville, Maryland | | | | | | 25a. REC'D BY REGISTRAR
DEC 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|--|--|--|---|---------------------|
| 17949 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17960 | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Ralph J. Sprague | | | | 2a. DATE OF DEATH Month Day Year
Dec 27 1968 | | | 2b. HOUR
1:10 AM |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
1-4-1898 | | 6. AGE (in years lost birthday)
70 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Wisconsin | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Gov't | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
md | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
Frank Sprague | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mabel DeWitt | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
Yes WW I | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT wife
Ella F. Sprague Address Same as Item 13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u>
4369 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>337X</u> DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Emphysema, congestive heart failure, renal insufficiency, pneumonia</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CRYSTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> , 19 <u>68</u> , to <u>12/27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Allen J. O'Neill</u> | | | | 22c. DATE SIGNED
12/27/68 | | 22d. PHYSICIAN'S NAME (Type)
Allen J O'Neill | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-30-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
JAN 2 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

17820

EXHIBIT IN CASE

17820

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17950

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17961

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | | |
|---|---------|--|--------|---|--------------------------|---|-----------------|--|--------------------------|--|
| 1. DECEASED NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | Month | Day | Year | 2b. HOUR |
| Paul Douglas Stokes | | | | | Dec 30 1968 | | | | | 5:30 P.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | |
| M | W | May 14 1946 | | 22 YRS | MONTHS DAYS | | HOURS MIN. | | Month Day Year | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | |
| Wash. DC | | U.S.A. | | WIDOWED | | DIVORCED | | Montgomery | | Md. |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Derwood | | 19713 Moncaster Rd | | | | Student | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Maryland | | Montgomery | | Derwood | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19713 Moncaster Rd | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| Ralph Gordon Stokes | | | | | Dorothy May Young | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| no | | 217-46-8896 | | Father | | Same as 11 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gun shot wound of Head | | | | | | | | | | Sudden |
| 955 X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 976 X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | 5:30 P.M. 12/30 1968 | | Shot self in head with Pistol | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | |
| | | Home | | 19713 Moncaster Rd | | Deerwood | | Montgomery | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | | | M.D. ASSISTANT MEDICAL EXAMINER | | | | | | |
| John G. Ball | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Dec 30 1968 | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) |
| Burial | | Jan. 2, 1968 | | Laytonsville | | Laytonsville | | Mont. | | Md. |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Francis H. Barber Laytonsville, Md. | | | | | | DATE JAN 6 1969 | | Charles Judge | | |

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UNITED STATES DEPARTMENT OF JUSTICE
BUREAU OF PRISONS

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John G. Ball

John G. Ball

John G. Ball

John G. Ball

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on both general and special pages, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17951

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17962

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) STONE | | | First Middle Last | | | 2a. DATE OF DEATH
Month 12 Day 22 Year 68 | | | 2b. HOUR
8:22 PM | | |
| 3. SEX
male | | | 4. RACE
White | | | 5. DATE OF BIRTH
Dec 22, 1968 | | | 6. AGE (In years last birthday)
YRS. MONTHS DAYS HOURS MIN
1 54 | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wash. San + Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY P.G. | | | 13c. CITY OR TOWN Landover | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
Thomas | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
Judy | | | First Middle Last Woody | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
PATIENTS CHART | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory + Cardiac ar.
7762
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Prematurity
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
773.5 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 22, 1968 , to Dec 22, 1968 , that (I) (we) lost saw the deceased alive on Dec 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
William Bryan, M.D. | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
Dec 22, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
W. Bryan, M.D. | | | | | | 22e. ADDRESS
7600 Carroll Ave, Takoma Park, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | 23b. DATE
12-24-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Washington San. & Hospital | | | 23d. LOCATION (City or Town) (County) (State)
7600 Carroll T.P. Mont. Md. | | |
| 24. FUNERAL DIRECTOR
J.D. Ruffcorn 7600 Carroll Ave. T. P. Md. | | | | | | 25a. REC'D BY REGISTRAR
DEC 27 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

17803

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1968 1001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17952

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17963

| | | | | | | | | | | | | | |
|--|--|------------------------------|--|--|--|---|---------------------------------|---|--|--|--|-----------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| Baby Girl | | | Stone | | | Month 12 Day 23 Year 68 | | | 6:25 AM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR | | | |
| Female | | White | | Dec 22, 1968 | | | — YRS. | | | MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | |
| Maryland | | USA | | | | | Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Takoma Park | | | | Wash. San + Hosp. | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Maryland | | | | P.G. | | Landover | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1876 Columbia Ave | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | Address | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | | | |
| Thomas | | | | Stone | | | | Judy Woody | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | |
| No | | | | | | | | PATIENTS CHART | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory + Cardiac Failure</u> | | | | | | | | | | 5h 45 min | | | |
| 7762 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) <u>Prematurity</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 773.5 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | HOUR A.M. Month Day Year | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | | | | | |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 22</u> , 19 <u>68</u> , to <u>Dec 23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | | | |
| <u>William Bryan, M.D.</u> | | | | | | | | | <u>Dec 23, 1968</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | | | |
| W. Bryan, M.D. 7600 Carroll Ave, | | | | | | Takoma Park, Maryland 20012 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 12/24/68 | | | Wash. San. & Hospital | | | Takoma Park Montgomery, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| J. Ruffcorn 7600 Carroll Ave, T. P. Maryland | | | | | | DEC 27 1968 | | | <u>J. Charles Judge</u> | | | | |

17583

REPUBLIC OF CHINA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|-------------------|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| MARGARET | | | (N) STONEBRAKER | | | December | | Day 8 Year 1968 6 A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | |
| Female | | White | | SEPT. 3, 1887 | | 87 YRS. | | 21 5 | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Wash DC | | U.S.A. | | | | MONTGOMERY Md | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BETHESDA | | | SUBURBAN HOSPITAL | | | HOUSEWIFE | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | MONTGOMERY | | CHEVY CHASE | | YES | | 4403 BRADLEY LANE | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last UNKNOWN | | | First Middle Last MacLennan | | | Marsda | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | | 578-01-8116 | | VAY STONEBRAKER | | 1324-Edgewood Lane, North Bethesda, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiorespiratory failure 12 hrs. after abdominal operation - Necrosis | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Intestinal obstruction | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cause undetermined - possibly infected bowel carcinoma | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| Severe inanition, Pneumonia, Arteriosclerotic heart disease, total phlebotomy | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 12/7/68 | | Intest. Obstruction | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/24, 1968, to 12/8, 1968, that (I) (we) last saw the deceased alive on 12/7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | |
| Joseph A. Romeo M.D. | | 12/8/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | |
| Joseph A. Romeo M.D. | | 8218 Wisconsin Ave., Bethesda, Md. | | | | | | | | |
| 23a. BURIAL OR CREMATION (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Rock Creek | | 12-11-68 | | Rock Creek | | Washington D.C. | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| ROBERT A. PUMPHREY | | | | DATE DEC 16 1968 | | Charles Judge | | | | |

11984

DEPARTMENT OF STATE

1973

OFFICE OF THE SECRETARY OF STATE

Washington

Rock Creek

12-11-83

SECRET

SECRET

11984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|-----------------------------------|-------------------------------|--|
| 17954 | | | | | | 17965 | | | | | |
| 1. DECEASED-NAME
(Type or print) Irma Lacey Street | | | | | | 2a. DATE OF DEATH
Dec. Month 5 Day 68 Year | | | | 2b. HOUR
1 a M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
6-20-10 | | 6. AGE (In years lost 58 day) YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Del. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Glenwood | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last
Roy D. Simpler | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Carrie Warrenton | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
579 42 9292 | | | 17. INFORMANT
Hospital Records | | | Address
Olney, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cachexia
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma, right breast with axillary & mediastinal spread
DUE TO, OR AS A CONSEQUENCE OF
(c) 19 mos.
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
170x | | | | | | | | | | | |
| 19a. DATE OF OPERATION
7/24/67 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cancer of rt. breast | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/11/1964 , to 12/5/1968 , that (I) xxx last saw the deceased alive on 12/5/1964 , and that in (my) xxx opinion death occurred on the date and hour and from the causes stated above, (I) xxx (did) xxx view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Charles S. Whitaker, M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/6/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Charles Whitaker | | | | | | 22e. ADDRESS
Ten Oaks Road
Clarksville, Md. 21029 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
12-7-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Bridgeville Memorial Bridgeville | | 23d. LOCATION (City or Town) (County) (State)
Del. | | | | | |
| 24. FUNERAL DIRECTOR
HIGHBOTHAM SLACK
FUNERAL HOME | | | | ADDRESS
ELICOTT CITY, MD | | 25a. DEC'D BY REGISTRAR
DEC 10 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

699 01035

CERTIFICATE OF DEATH

17955

17966

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEASED NAME
(Type or print) <i>HAZEL</i> | | First Middle Last
<i>L. SWARD</i> | | 2a. DATE OF DEATH
Month <i>12</i> Day <i>29</i> Year <i>68</i> | | 2b. HOUR
M | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>1-16-1891</i> | | 6. AGE (In years last birthday)
<i>77</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Iowa</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during usual of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Cherry Chase</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
<i>William F. Leimbough</i> | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Anna Chaderin</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, or unknown) (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
Address
<i>George G. Sward 2825 Greenvale St. Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4129 Atherosclerotic Heart Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>unk.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>4200</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/27</i> , 19 <i>68</i> , to <i>12/29</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/28</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Allen M. Mondz</i> MD DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/29/68</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>ALLEN M. MONDZ</i> | | | | 22e. ADDRESS
<i>5904 CHATSWORTH AVE Bethesda</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>1-2-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Suitland Prince G. Md.</i> | |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS
<i>7557-Wisconsin Ave.. Bethesda. Md.</i> | | | | 25a. REC'D BY REGISTRAR
DATE <i>JAN 6 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17908

RECEIVED OF DEATH

12-29-68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Eleanor W. Swartwood | | | | | Dec. 12 1968 | | | 39 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | |
| female | | white | | 10-16-84 | | 84 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Pennsylvania | | U. S. A. | | | | Montgomery. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | Suburban Home | | private | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Mont. | | Cherry Chase | | | | 4702 - Cherry Chase St. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| First Middle Last | | First Middle Last | | | | Beatrice Collins | | Same As Above | |
| Carlos Frances Weaver | | Aledia | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| No | | No | | Beatrice Collins | | Same As Above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Anteroseptal myocardial infarction | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Coronary arteriosclerosis obliterans | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/8, 19 68 to 12/12, 19 68, that (I) (we) last saw the deceased alive on 12/12, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| Robert R. Montgomery, M.D. | | 12/15/68 | | ROBERT R. MONTGOMERY, M.D. | | | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | | | | | | |
| | | 5411 CEDAR LANE BETHESDA, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 12-16-68 | | Mt. View Cemetery | | Wellsburg, New York | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | DATE DEC 18 1968 | | Charles Judge | |

Letter to the President
of the United States

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 116
45M 11 69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last | | | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
M | | | |
| Robert J. Swingle | | | | | Dec 3 1968 | | | 5:17 | | | |
| 3. SEX
MALE | | 4. RACE
white | | 5. DATE OF BIRTH
10-30-86 | | 6. AGE (In years last birthday)
82 | | 7. YRS.
MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country)
Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Ret. Field Inspect. | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5601 GROSVENOR LN. | | | |
| 14. FATHER'S NAME
Robert D. Swingle | | | 15. MOTHER'S MAIDEN NAME
Emma Catherine Johnston | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
Yes | | 16b. SOCIAL SECURITY NO.
W.W. L | | 17. INFORMANT
Mrs. Asha W. Swingle, | | Address as above. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
4119 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY
(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 8, 1967, to Dec. 3, 1968, that (I) (we) lost the deceased alive on Dec. 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert G. Angle M.D. | | | | DEGREE
ROBERT G. ANGLE, MD. | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Dec. 3, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT G. ANGLE, MD. | | | | 22e. ADDRESS
5009 DelRay Ave. Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Geo. Washington Cem. | | 23d. LOCATION (City or Town) (County) (State)
Hyattsville, Montg. Md. | | | | | |
| 24. FUNERAL DIRECTOR
Robert A. Pomphrey, Bethesda, Maryland | | | | 7557 Wisconsin Ave.
ADDRESS | | 25a. REC'D BY REGISTRAR
DATE DEC 9 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

83251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|------------------------|--|
| <div>17958</div> <div>CERTIFICATE OF DEATH</div> <div>17969</div> | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR PM | | |
| William Anthony Taddeo | | | | | | December 19 1968 | | 10:00 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| Male | | White | | June 12, 1939 | | 29 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| New Jersey | | USA | | | | Montgomery | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | The Clinical Center, NIH | | | Warehouse Supervisor | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| New Jersey | | | -- | | Union | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 916 Lakeside Place | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Ned Taddeo | | | Mary LaFerrara | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT The Medical Record Address | | | | | |
| Yes | | | 1959-1961 | | The Clinical Center, Bethesda, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis, shock
2050 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute Myelogenous Leukemia
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 Hours
1 1/2 Years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
204.3 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | 19 | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from December 3, 1968, to December 19, 1968, that (X) (we) last saw the deceased alive on December 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Brian W. Goodell | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
20 December 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) Brian W. Goodell, M. D. | | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 12/24/68 | | Gate of Heaven Cemetery | | Hanover, New Jersey | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home-1551 Rockville Pike
Rockville, Md. | | | | | 25. REC'D BY REGISTRAR
DEC 26 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |



80/45/52

[illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17959

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17970

| | | | | | | | | |
|---|--|---------------------------|--|--|--|--|--|---|
| 1. DECEASED NAME
(Type or Print) <i>Andrew Clifford Tait</i> | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>Dec. 9 1968</i> | | | 2b. HOUR <i>8:30</i> M. | | |
| 3. SEX <i>male</i> | | | 4. RACE <i>white</i> | | | 5. DATE OF BIRTH <i>4/4/1915</i> | | |
| 6. AGE (in years last birthday) <i>53</i> YRS. | | | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Conn.</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. COUNTY OF DEATH <i>Montgomery</i> | | | 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Boat.</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | 13a. STREET AND NUMBER <i>3316 North Ruston Dr.</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Va.</i> | | | 13b. CITY OR TOWN <i>Charlottesville</i> | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First <i>Andrew</i> Middle <i>Tait</i> Last <i>Tait</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Laura</i> Middle <i>Wilson</i> Last <i>Wilson</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | | 16b. SOCIAL SECURITY NO. <i>070-05-0612</i> | | | 17. INFORMANT <i>Reid C. Tait</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i> | | | | | | | | <i>Sudden</i> |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) <i>Coronary Artery Disease</i> | | | | | | | | <i>years</i> |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) <i>Arterio-Sclerosis-Generalized</i> | | | | | | | | <i>years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| <i>4201</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <i>Dec. 9, 1968</i> | | |
| EXAMINER'S NAME (Type) <i>John G. Ball M.D.</i> | | | M.D. <i>7936 Old Geo. Rd.</i> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county) <i>Bethesda, Maryland</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>12/13/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Govanstown Presby. Ch.</i> | | 23d. LOCATION (City or Town) <i>Baltimore</i> | | (County) <i>Maryland</i> (State) |
| 24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i> | | | | ADDRESS <i>1331 Rock. Pike</i> | | 25a. REC'D BY REGISTRAR <i>DEC 16 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |
| | | | | Rockville, Md. | | | | |

11370

RECEIVED - EXAMINER'S OFFICE

RECEIVED - EXAMINER'S OFFICE

1

11370

RECEIVED - EXAMINER'S OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|--|--|------------------------------|--|
| 12/31/68 11w 17960 CERTIFICATE OF DEATH 17971 | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) George First Tait Middle Tait Last | | | | | | 2a. DATE OF DEATH
Month December Day 17 Year 1968 | | | 2b. HOUR
8 A/M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
8-18-1876 | | | 6. AGE (In years lost birthday)
92 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Wash, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
259 Congressional Lane | | | 12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.P.O. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Montgomery | | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
259 Congressional Lane | | | | | |
| 14. FATHER'S NAME First Joseph Middle Tait Last | | | | 15. MOTHER'S MAIDEN NAME First Henrietta Middle Mullen Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
579 60 1140 | | 17. INFORMANT
Mary A. Tait | | Address
Same as 13 abcde | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage
4339
DUE TO, OR AS A CONSEQUENCE OF
(b) Stress ulceration of stomach.
DUE TO, OR AS A CONSEQUENCE OF
(c) Recurrent Cerebral Thrombosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
332x Renal Failure | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 16, 1968 , to Dec 17, 1968 , that (I) (we) last saw the deceased alive on Dec 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
James R. Moore Jr | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Dec 17, 1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
James R. Moore Jr | | | | | | 22e. ADDRESS
570 N. Frederick Ave Gaithersburg | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-14-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Congressional | | | | 23d. LOCATION (City or Town) (County) (State)
Wash, D.C. | | | | |
| 24. FUNERAL DIRECTOR
Robert A. Mathingley | | | | ADDRESS
131-11 N.E. Wash | | 25a. REC'D BY REGISTRAR
DEC 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

17881

RECEIVED OF DEPT

17881



17881



17881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17961

17972

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|--------------------------------|--|
| 1. DECEASED-NAME
(Type or print) <i>Leslie Britton Taylor</i> | | | 2a. DATE OF DEATH
Month <i>Dec.</i> Day <i>17</i> Year <i>1968</i> | | | 2b. HOUR
<i>P. M.</i> | | | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
<i>3-26-90</i> | | 6. AGE (In years
lost birthday)
<i>78</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) <i>New Jersey</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>Amer.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery Co.</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Washington San. & Hosp. Grounds Care of Wash.</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE <i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Spencerville</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>1901 Spencerville Rd.</i> | | |
| 14. FATHER'S NAME
First <i>Benjamin B.</i> Middle <i>Taylor</i> Last <i>Taylor</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Elizabeth D.</i> Middle <i>Wilson</i> Last <i>Wilson</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>141-16-0272</i> | | 17. INFORMANT
<i>Patient & Wife</i> | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Electrolyte Imbalance & Anoxemia</i>
<i>600x</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. <i>610x</i>
(b) <i>Acute Renal Failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Left Vascular Obstruction & R. Vascular Hypoplasia</i> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Benign Prostatic Hypertrophy, Postural Hypertension & Self-Induced Trauma</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>12-16-68</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Hematuria</i> | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? <i>yes</i> | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/10</i> , 1968, to <i>12/17</i> , 1968, that (I) (we) last
saw the deceased alive on <i>12/17</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Douglas R. Batts MD</i> | | | DEGREE | | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/18/68</i> | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | 22e. ADDRESS
<i>831 University Blvd E. Silver Spring Md</i> | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE
<i>Dec. 20, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>George Washington</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Adelphi Md</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>John J. Patterson</i> | | | ADDRESS
<i>254 Bernall St NW</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>DEC 20 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Charles Judge</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Coroner, Dr. Borden Keap.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|------------------------|--------------------------------|--|
| 17982 | | MARY | | | | 17973 | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
MARY WILSON TAYLOR | | | | | | 2a. DATE OF DEATH
Month Day Year
12 12 68 | | | 2b. HOUR
10 50 A.M. | | |
| 3. SEX
Female | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
9-6-01 | | 6. AGE (In years lost birthday)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. America | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON SAN+HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
clerk - HECHT Co. | | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
S. Sp. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
233 Whitmoor Terr. | | | |
| 14. FATHER'S NAME First Middle Last
Lee -- Wilson | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ida -- Laird | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
213-14-6075 | | 17. INFORMANT
John C. Phacey | | | Address
Sil. Spr. Md.
233 Whitmoor Terr. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC TAMPNAD</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>RUPTURE OF POSTERIOR APICAL MYOCARDIUM</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>POSTERIOR APICAL MYOCARDIAL INFARCTION</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES
SUDDEY
16 HOURS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-11</u> , 19 <u>68</u> , to <u>12-12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Scruch T. Kimble, MD | | | | DEGREE
ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | 22c. DATE SIGNED
12-12-68. | | | |
| 22d. PHYSICIAN'S NAME (Type)
Scruch T. Kimble, MD | | | | 22e. ADDRESS
9801 Georgia Ave. S.S. Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-15-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Monokon Presbyterian Church Cem. | | 23d. LOCATION (City or Town) (County) (State)
Princes Anne, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
J.W. Lee
Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | ADDRESS
Sil. Spr. Md. | | 25a. REC'D BY REGISTRAR
DEC 19 1968 | | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardan paper, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Deceased by Dr. Lee - Medical Certificate

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|--|---|--|--|---|--|
| 17903 | | | | | 17974 | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR | |
| Mrs Minerva H. Taylor | | | | | December 16 1968 | | | 7 ³⁰ p. M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Female | | White | | November 24, 1881 | | 87 | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| New Jersey | | U.S.A. | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Wheaton | | Kanglich Hills Nursing Home | | housewife | | own home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Silver Sp. Md | | Montgomery | | Silver Spring | | YES | | 2108 Belvedere Boulevard | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Christian A. Nail | | | Cornelia -- Sweet | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| No | | -- | | 192-26-1548-D | | H. Laessle Taylor 4105 Southend Road Rockville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>30 yrs</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 weeks</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>2201 wound</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>23 Oct</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| <u>James M.D.</u> | | 16 Dec 68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Bul T. Nourse M.D. | | 520 Rockville, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 12-21-1968 | | Greenwood Cemetery | | Trenton, New Jersey | | | |
| 24. FUNERAL DIRECTOR <u>J.W. Lee</u> ADDRESS <u>Sil. Spr. Md.</u> | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | DEC 23 1968 | | <u>James Judge</u> | | | |

1875

UNITED STATES



FOR STATE
HEALTH DEPT.

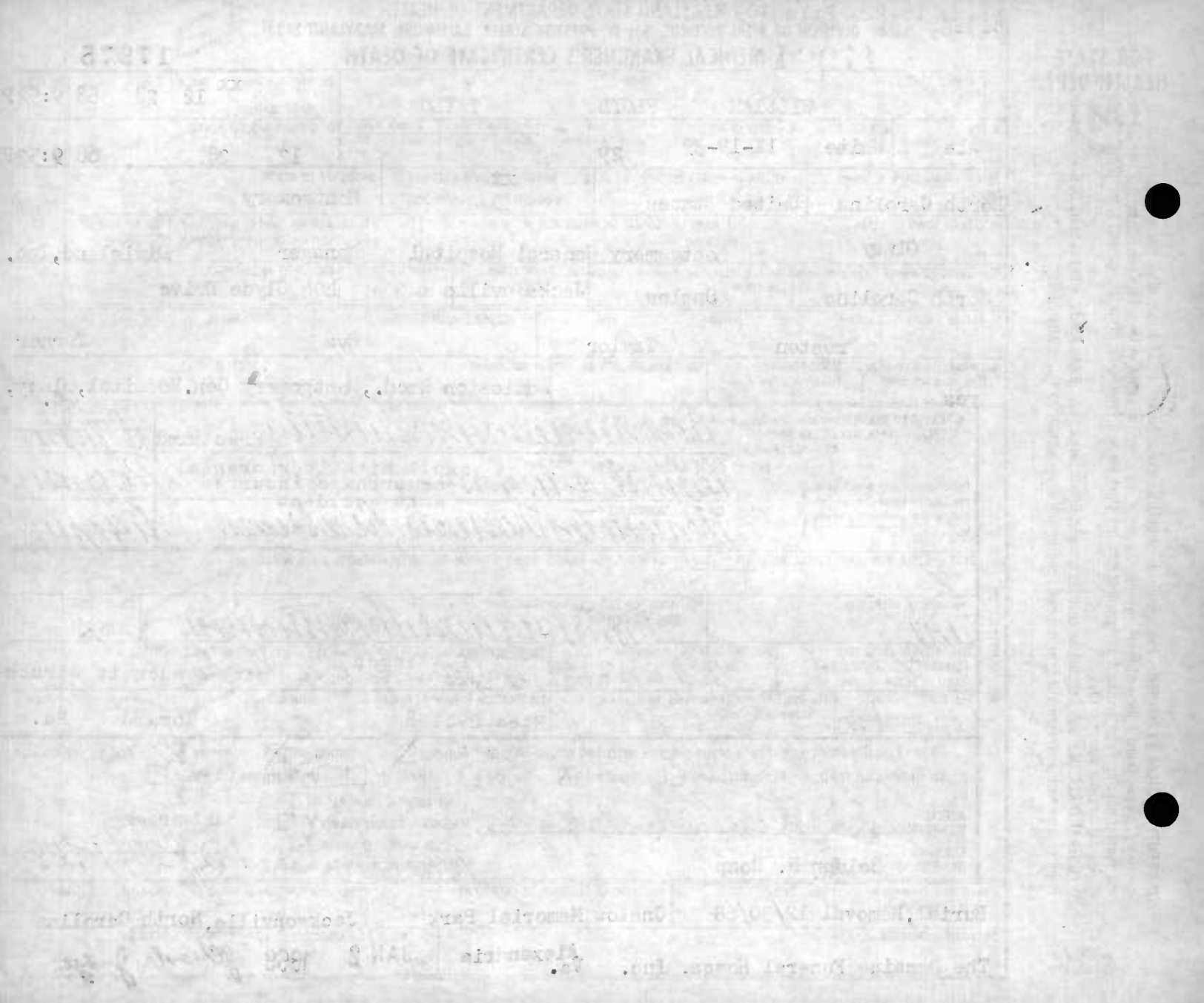
17984 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17975

| | | | | | | | | | | | | | | | |
|--|--|---------|--|--|--|--|--|---|---|------------------|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | | |
| WILLIAM FLOYD TAYLOR | | | | | | 12 28 68 | | | 9:52 PM | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | |
| Male | | White | | 11-19-39 | | 29 YRS. | | MONTHS DAYS | | HOURS MIN | | Month Day Year 12 28 19 68 | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | | |
| North Carolina | | | United States | | | | | | Montgomery | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Olney | | | Montgomery General Hospital | | | Manager | | | Dixieland, Inc. | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | |
| North Carolina | | | Onslow | | | Jacksonville | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 404 Clyde Drive | | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | | | | | |
| Preston Taylor | | | | | | Eva Turner | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | |
| yes | | | | | | Admission Recd., Montgomery Gen. Hospital, Olney, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>816.1</u> <u>Concussion, Brain Stem Fractured</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>Central Edema</u> skull with intracranial hemorrhage incurred in <u>auto accident</u> | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Traumatic Necrosis, Cerebrum</u> <u>Barry</u> | | | | | | | | | | | | | | | |
| (c) <u>8234</u> | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>1/24</u> | | | | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Uncontrolled Hypertension</u> | | | | | | | | | | | | | | | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year <u>Dec 25 19 68</u> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Thrown from Auto when it struck a tree</u> | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Street</u> | | | | 21f. LOCATION Street or R.F.D. No. <u>Rtes. 29&108</u> City or Town <u>Howard</u> County <u>Howard</u> State <u>Md.</u> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>12/29/1968</u> | | | | | | | |
| EXAMINER'S NAME (Type) <u>Belden R. Reap</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial, Removal | | | | 12/30/68 | | | | Onslow Memorial Park | | | | Jacksonville, North Carolina | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| The Demaine Funeral Homes, Inc. | | | | Alexandria Va. | | | | DATE JAN 2 1969 | | | | <u>Charles Judge</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|---------|--|---------|--|--|---|--------------------------------|-----------------------------------|---|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year
OF ESTI-
DEATH MATED <input type="checkbox"/> Dec 24 19 68 | | | | 2b. HOUR
1 38 M |
| Clara | | B. | Terhune | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year 1968 |
| Female | White | 4-10-82 | | 86 YRS. | | | | | 2d. HOUR
1 38 M |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| New Jersey | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | Suburban | | | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Montgomery | | Chevy Chase | | | | 4125 Leland Street | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| Edward | | C | Bennett | | Annie | | E. | Whitlock | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | 020-18-9203 | | Mrs. T. Harold Scott - Daughter | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cardio Vascular Disease-</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Generalized Arterio Sclerosis.</u> | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>4 hr.</u>
<u>years</u>
<u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>9047</u>
<u>Fracture of Left Hip.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | |
| Dec-24, 1968 | | Repair of fracture of left hip. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. Dec 22 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>Fall in nursing home.</u> | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
<u>Nursing Home.</u> | | 21f. LOCATION Street or R.F.D. No.
<u>Potomac Valley Nursing Home.</u> | | City or Town <u>Rockville</u> County <u>Mont.</u> State <u>Md.</u> | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL
SIGNATURE | | EXAMINER'S
NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED
<u>Dec 24, 1968</u> | | | |
| John W. Ball | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Removal | | 12/26/68 | | Bound Brook Cemetery | | Bound Brook, N. Jersey | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| The S.H.Hines Company Washington, D.C. | | | | DEC 27 1968 | | J Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 17986 | | | | | 17977 | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | | |
| First MARY Middle E. Last Thiesen | | | | | Month Dec. Day 27 Year 1968 125 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| female | | white | | 2/16/1895 | | 73 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| New York | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Colonial Villa Home | | Nursing Secretary | | U.S. Gov't | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| STATE | | Washington | | | | 1916 17th St. N.W. | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Patrick Sexton | | | Mary Collins | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| no | | | 378-10-3576A | | | Nursing Home Records (same as above) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal rectal cancer</u> | | | | | | | | 2 years | |
| 1541 DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 154x Recurrent urinary tract infections. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 20, 1968, to Dec 27, 1968, that (I) (we) last saw the deceased alive on Dec 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Donald W. Datlow, M.D.</u> DEGREE | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>Dec 27, 1968</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Donald W. Datlow, M. D.</u> | | | | 22e. ADDRESS <u>823 Univ. Blvd. West. Silver Spg</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Removal | | 12/28/68 | | St. Raymond's Cemetery Bronx, New York | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| The S. H. Hines Co. Washington, D. C. | | | | DEC 31 1968 | | Charles Judge | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | |
|---|-----------------------------|---|--|---|
| 1. DECEASED-NAME
(Type or Print) <i>Alice Elizabeth Thomas</i> | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>12</i> Day <i>15</i> Year <i>1968</i> | | 2b. HOUR <i>2:35</i> PM |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH <i>3-22-1890</i> | 6. AGE (In years last birthday) <i>78</i> YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <i>Montgomery</i> Md. |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Accountant</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | 13c. CITY OR TOWN <i>Sandy Springs</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME First <i>Joseph</i> Middle <i>R.</i> Last <i>Thomas</i> | | 15. MOTHER'S MAIDEN NAME First <i>Alice</i> Middle <i>G.</i> Last <i>Jawcett</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>577-03-6229</i> | | 17. INFORMANT <i>Frank J. Thomas</i> ADDRESS <i>3278 Gleneagles Dr. S.S. Md.</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerotic Heart Disease</i>
(b) <i>Arteriosclerotic Heart Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <i>Dec. 15, 1968</i> |
| EXAMINER'S NAME (Type) <i>R. Belden R. Reap</i> M.D. | | ADDRESS <i>Rock Creek Cemetery</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE <i>12-18-1968</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i> | 23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i> | |
| 24. FUNERAL DIRECTOR <i>M. Andrew Dwyall Warner E. Pumphrey, Inc. 8434 Georgia Ave.</i> | | 25a. REC'D BY REGISTRAR <i>DEC 23 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i> |

THE STATE
OF NEW YORK



CERTIFICATE OF DEATH

1928

| | | | | | |
|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Sex | | Age | |
| Date of Birth | | Date of Death | | Place of Death | |
| Cause of Death | | Manner of Death | | Occupation | |
| Signature of Physician | | Signature of Registrar | | Signature of Coroner | |
| Date of Certificate | | Place of Certificate | | County | |

CERTIFICATE OF DEATH

17979

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) Eunice | | First B. | | Middle Thomas | | Last | | 2a. DATE OF DEATH
Dec Month 22 Day 68 Year | | | | 2b. HOUR
11:16 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
3/1/92 | | | | 6. AGE (In years
last birthday)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Suburban Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
9804 Montauk Avenue | | | |
| 14. FATHER'S NAME First William Middle Anadale Last | | | | 15. MOTHER'S MAIDEN NAME First Florence Middle Belfield Last | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
A. Russell Thomas Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
433.9
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral arteriosclerosis
332.x
DUE TO, OR AS A CONSEQUENCE OF
(c) Did and recent myocardial infarction | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
15 days
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Did and recent myocardial infarction | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 7, 1968 , to Dec 22, 1968 , that (I) (we) last
saw the deceased alive on Dec 21, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Robert R. Montgomery, MD | | | | | | | | | | | | 22c. DATE SIGNED
12-24/1968 | |
| 22d. PHYSICIAN'S NAME (Type) ROBERT R. MONTGOMERY, MD | | | | | | | | | | | | 22e. ADDRESS
5911 CEDAR LANE BETHESDA, MD | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
Dec. 26, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
National Mem. Park Cem. | | | | 23d. LOCATION (City or Town) (County) (State)
Falls Church, Virginia | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc. | | | | 25a. REC'D BY REGISTRAR
5130 Wisc. Ave. N.W. Wash., D.C. | | | | 25b. REGISTRAR'S SIGNATURE
DEC 30 1968 | | 25c. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
17980 | | | | | | | | | | 17980 | | |
|--|--|--|--|---|---|--|--|--|---|----------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
KATHERINE E. THOMAS | | | | | 2a. DATE OF DEATH
Month Day Year
12 7 68 | | | | | 2b. HOUR
7:00 AM | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
2-19-01 | | | 6. AGE (In years lost birthday)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
67 | | IF UNDER 24 HRS.
HOURS MIN
67 | |
| 7a. BIRTHPLACE (State or foreign country)
New Jers. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New Jersey CO. Camden | | 13b. CITY OR TOWN
Camden | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
422 Grant Street | | | | | | |
| 14. FATHER'S NAME First Middle Last
Edward -- Rubright | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lotti -- Hoffman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
150-10-4006 | | 17. INFORMANT
Address
Edward H. Thomas 8308 26th Place, Adelphi, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) URINARY TRACT INFECTION, SEPSIS? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis 26 YEARS.
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS. 6 YEARS. | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260X CORONARY HEART DISEASE, OLD MYOCARDIAL INFARCTIONS. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 18, 19 64 , to December 7, 19 68 , that (I) (we) last saw the deceased alive on December 7, 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Hugo G. Graziani, MD. DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
12/7/68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
HUGO G. GRAZIANI | | | | | 22e. ADDRESS
10101 GEORGIA AVENUE, SILVER SPRING, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-11-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Beth El Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Pennsauken, New Jersey | | | | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. ADDRESS Sil. Spr., Md. | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 12 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17981

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5811 Colonsville Road #106</u> | | d. STREET ADDRESS <u>5811 Colonsville Rd #106</u> | |
| 3. NAME OF DECEASED (Type or print) <u>CHARLES HENRY THOMPSON</u> | | 4. DATE OF DEATH <u>Dec. 15</u> 19 <u>68</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 12, 1892</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATT. AT LAW</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT CO., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOHN P. Thompson</u> | | 14. MOTHER'S MAIDEN NAME <u>ETHEL BOONE</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>212-01-7276</u> | |
| 17. INFORMANT <u>MARGARET Thompson-Wife</u> | | Address <u>5811 Colonsville Rd</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
DUE TO <u>4109</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Arterio-sclerotic heart disease</u>
(c) <u>Arteriosclerosis - generalized</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>1 year</u>
<u>5 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> o.m. p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>67</u> , to <u>Dec 15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 13</u> , 19 <u>68</u> , and that death occurred at <u>8:00 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Harry N. Carlton</u> | | 22b. DATE SIGNED <u>Dec 15, 1968</u> | |
| 22c. PHYSICIAN'S NAME (Type or print) <u>HARRY N. CARLTON</u> | | 22d. ADDRESS <u>5811 Colonsville Rd, SS, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12-17-1968</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., 5130 Wisconsin Ave. N.W., Wash., D.C., 20016</u> | | 25a. REC'D BY REGISTRAR <u>DEC 19 1968</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

18271

[Faint handwritten notes, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~these~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|---|---|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 17982 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Claudia | | | Thomson | | | 12 Month 10 Day 68 Year | | | 11:10 AM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| Female | | White | | May 7, 1886 | | | 87 YRS. | | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| So. Dakota | | U.S.A. | | | | MONTGOMERY Co. Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| SILVER SPRING | | | CHEVY CHASE NURSING & CON. CENTER | | | Agriculture Dept. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| -- DC | | | | | Washington | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1636 Kenyon St. N. W. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Thomas Thomson | | | Eli Engebretsen | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| Yes, no, or unknown | | | | | decedent - | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4129 PNEUMONIA | | | | | | | | | 48 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Vascular Disease | | | | | | | | | Years - |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arterio Sclerosis generalized. Severe | | | | | | | | | Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 Aug 1967, to date, 1968, that (I) (we) last saw the deceased alive on Nov-29-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| John G. Ball | | | | | | | | Dec 10, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| George G. Ball | | | | 7936 Old Georgetown Rd. | | | | | |
| | | | | Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Removal | | 12/11/68 | | Mountain View Cemetery | | Rapid City, S. Dakota | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| The S.H. Hines Co. | | | | 2901 14th ST. NW | | DEC 16 1968 | | Charles Judge | |

17832

UNITED STATES OF AMERICA

St. Charles, U.S.A.

1830 George St. S.W.

Washington

D.C.

Thompson

Thompson

Thompson

George St. S.W.

1830 George St. S.W.

Washington, D.C.

17832

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---|---|---|--------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
M |
| Annie Viola Titus | | | | | | Dec 7 1968 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | | White | | Dec. 18-1877 | | 90 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Virginia | | US | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Poolesville | | | | | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Montg. | | Poolesville | | | | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| William Frye | | | Annie Bales | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address | | | | |
| No | | | 315-54-7420 | | Mrs Betty Titus, Poolesville, Md | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>
<u>4369</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Atherosclerosis, Generalized</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 days</u>
<u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
<u>331X</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>13 April, 1954</u> , to <u>7 Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6 Dec</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| <u>Gordon Murdoch Smith MD</u> | | <u>7 Dec 68</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Gordon Murdoch Smith, MD | | Barnesville, Md 20703 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| <u>Buried</u> | | <u>12/19/68</u> | | <u>Monocacy</u> | | <u>Beallsville Montg Md</u> | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| <u>William D. Hilton</u> | | <u>DEC 11 1968</u> | | <u>Charles Judge</u> | | | | | |

11283

DEC 1 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------|--|--|--|--|--|---|--|---|--|---|--|--------------------------------|--|--|--|--|--|-----------------------|--|--|--|-------|--|--|--|
| 17973
Tofsky Jacob | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 17984 | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Tofsky Jacob Tofsky | | | | | | | | | | | | 2a. DATE OF DEATH
Month Day Year
Dec. 14 1968 | | | | | | | | 2b. HOUR
9:15 A.M. | | | | | | | |
| 3. SEX
M | | 4. RACE
W. | | 5. DATE OF BIRTH
12/15/19? | | | | 6. AGE (In years last birthday)
78 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery Co. Md. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring Md. | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
BUYER (RET) | | | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | 13b. COUNTY
Montg. | | | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
10401 Grosvenor Place | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
JACOB N. TOFSKY | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
LEAH ? | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO | | | | 16b. SOCIAL SECURITY NO.
075-20-7520 | | | | 17. INFORMANT
SON, IRVING TOFSKY SAME AS 12 | | | | Address | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CARDIAL ARRHYTHMIA - CORONARY DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.
4129 2 YEARS 2-3 yrs +
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 NONE | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY, 1968, to DEC 13, 1968, that (I) (we) last saw the deceased alive on DEC 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
F.C. MAYLE MD | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
DEC 14 1968 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
F.C. MAYLE MD | | | | | | | | 22e. ADDRESS
6218 WISCONSIN AVE BETHESDA MD 20814 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE
12-16-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
NATHL MEM. PARK | | | | 23d. LOCATION (City or Town) (County) (State)
FALLS CHURCH VA | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
GOLDBERG FUNERAL HOME 4217 9TH ST. N.W. | | | | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 23 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | |

18071

11430 10-20-39

11430 10-20-39

11430 10-20-39



11430 10-20-39

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15-14
45M - 1968

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--------------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Agnes B. Tucker</i> | | | | | | 2a. DATE OF DEATH
Month <i>12</i> - Day <i>19</i> - Year <i>68</i> | | | 2b. HOUR <i>7:00</i> M | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH
<i>2-3-94</i> | | | 6. AGE (In years last birthday) <i>74</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <i>Penna.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> | | | Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Hospital D.O.A.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY <i>Montgomery</i> | | | 13c. CITY OR TOWN <i>Bethesda</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>8710 Lowell Street</i> | |
| 14. FATHER'S NAME First <i>James</i> Middle <i>Boner</i> Last <i>Boner</i> | | | | 15. MOTHER'S MAIDEN NAME First <i>Frances</i> Middle <i>Harrison</i> Last <i>Harrison</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) <i>****</i> | | | | 16b. SOCIAL SECURITY NO. <i>579-60-4458</i> | | 17. INFORMANT <i>Mrs Nancy Gilfrich</i> | | | Address <i>8710 Lowell St.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Right sided cardiac failure</i>
<i>492X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>pulmonary emphysema</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 yr.</i>
<i>yr's</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>5271</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 18, 1968</i> , to <i>Dec 17, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 17, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Alfred S. Norton</i> M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED <i>Dec 20 1968</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>ALFRED S. NORTON, M.D.</i> | | | | | | 22e. ADDRESS <i>7710 Dwight Dr. Bethesda, Md. 20014</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>12/23/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY,</i> | | 7557 Wisconsin Ave. <i>Bethesda, Maryland</i> | | 25a. REC'D BY REGISTRAR <i>DEC 26 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | |

MEDICAL CERTIFICATION

14082

STATEMENT OF DEBIT

1968

(M)



1968
DEC 10 1968
JAN 10 1969
FEB 10 1969
MAR 10 1969
APR 10 1969
MAY 10 1969
JUN 10 1969
JUL 10 1969
AUG 10 1969
SEP 10 1969
OCT 10 1969
NOV 10 1969
DEC 10 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 17975 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17986 | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|------------------------|--|--|------------------------|--|--|-------|--|----------|-----|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| KATHRYNNE MARIA UNKLE | | | | | | | | | | Month 12 Day 27 Year 1968 | | | | | | | | | | 7:00 PM | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| FE | | | WHITE | | | 6-25-1899 | | | 69 YRS. | | | MONTHS | | | DAYS | | | HOURS | | | MIN | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | NEVER MARRIED | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | |
| Maryland | | | U.S.A. | | | WIDOWED | | | DIVORCED | | | MONTGOMERY | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| TAKOMA PARK | | | WASHINGTON SAN. & HOSP. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| Mash. DC | | | | | | Wash. DC | | | YES | | | NO | | | 3015 CHANNING ST. N.E. | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JOHN | | | BEALL | | | MARGARET | | | BROWN | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | Marion Miller, R.N. | | | Wash. San. H. | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Minutes | | | | | | | | | | | | | | | | | | | |
| 450x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Minutes | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | Hours to | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Days | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 465x Previous myocardial infarction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 12/23/68 | | | Pneumothorax left | | | YES | | | NO | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | | HOUR A.M. Month Day Year P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | Street or R.F.D. No. | | | City or Town | | | County | | | | | | | | | | | | | | |
| While at work | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/22, 1968, to 12/27, 1968, that (I) (we) last saw the deceased alive on 12/27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Kenneth Cruz M.D. | | | 12/27/68 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | |
| KENNETH CRUZ | | | 831 University Blvd E. Silver Spring Md | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | | (County) | | | (State) | | | | | | | | | | | | | | |
| Burial | | | 12-31-1968 | | | Cedar Hill | | | Luitland | | | B. & A. Rd | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | |
| R.A. Mattingly | | | 131-11th St. SE. | | | JAN 2 1969 | | | Charles Judge | | | | | | | | | | | | | | | | | | | | |

17882

DEATH

JAN 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|---|---|--|--|
| Item 23 Film 408 1/3/69 kk | | | | | | | | | | | |
| CERTIFICATE OF DEATH 17987 | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) ALICE | | | | | | 2a. DATE OF DEATH DEC Month 18 Day 1968 | | 2b. HOUR 1007PM | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH FEB 11, 1920 | | 6. AGE (In years lost birthday) 48 YRS. | | 7. UNDER 1 YEAR MONTHS 0 DAYS 0 | | 7. UNDER 24 HRS. HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during life, even if retired.) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admittance) VIRGINIA | | | 13b. COUNTY ALEXANDRIA | | 13c. CITY OR TOWN ALEXANDRIA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 4639 RALEIGH AVENUE | | |
| 14. FATHER'S NAME First THOMAS Middle J. Last FLYNN | | | 15. MOTHER'S MAIDEN NAME First ELIZABETH Middle OWENS Last OWENS | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) NO | | | | | |
| 16b. SOCIAL SECURITY NO. -- | | | 17. INFORMANT Address 4639 RALEIGH AVE ALEXANDRIA, VA. (HUSBAND) MICHAEL E. VALLARIO | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Ovary with Metastases | | | | | | | | | | | |
| 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1750 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPT 29 , 19 68 , to DEC 18 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DEC 18 , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did (and not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE J. G. Fleming | | DEGREE ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 19 DEC 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) J. G. Fleming (M.D.) | | 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 12/24/68 | | 23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEMETERY | | 23d. LOCATION (City or Town) SCRANTON (County) PENNSYLVANIA (State) | | | | | |
| 24. FUNERAL DIRECTOR EVERLY-WHEATLEY | | ADDRESS 1500 WEST BRADDOCK RD., ALEXANDRIA, VIRGINIA | | 25a. REC'D BY REGISTRAR DEC 24 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

3314A

14

VALLEY

2.1

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USP 111 833

ALVAY 2M39

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Y83:KDT

BETHESDA

JAT 192011-17934

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3007-1-101-3145-020

ZAVOJE

July 19

HEALTH

112

new drug

4030

Table 1. Continued

0001 Y 940 10234734 10719021 10VAV0

(C.N) 0010019 .0 .5

1987-1988

Y. Y. ZHANG, J. K. KANG, AND J. H. KIM

Y²⁺ TAT²⁺ Y²⁺

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME
(Type or print) | | | | 2a. DATE OF DEATH | | 2b. HOUR | | | |
|---|--|--|--|---|--|--|--|--|--|
| First
HARRY | | Middle
J. | | Last
VAN PELT | | Month Day Year
12-13-68 | | 4:00 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Nov. 11, 1898 | | 6. AGE (In years last birthday)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Manager, Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Shoe Store | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2613 East-West Highway | |
| 14. FATHER'S NAME
First Middle Last
Samuel P. Van Pelt | | 15. MOTHER'S MAIDEN NAME
First Middle Last
- - - unknown - - - | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
345-05-2497A | | 17. INFORMANT
Address
Mrs. Mary K. Van Pelt 2613 East West Highway WAY | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarct'n
4100 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE YLS
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIOVASC. DIS. YRS.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
less 1 day | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 65 , to 12/13 , 19 68 , that (I) (we) last saw the deceased alive on 12/13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
G. Leonard Gold DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
12/13/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
G. Leonard Gold M.D. | | | | | 22e. ADDRESS
9801 Georgia Avenue Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-16-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville Mont. Md. | | | |
| 24. FUNERAL DIRECTOR
M. Andrew Duwall ADDRESS
Warner E. Pumphrey Inc. 8434 Ga. Avenue S.S. | | | | | 25a. REC'D BY REGISTRAR
DATE
DEC 19 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | |

83851

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|-------------------------------|--|--|--|---------------------|--|--|--|
| 17978 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 17989 | | | |
| 1. DECEASED-NAME
(Type or print) Hugo D. Vechery | | | | | | | | | | | | 2a. DATE OF DEATH
December Month 19 Day 68 Year | | | | | | | | | | | | 2b. HOUR
2:10 PM | | | |
| 3. SEX
Male | | | | 4. RACE
White | | | | 5. DATE OF BIRTH
Sept 4, 1875 | | | | 6. AGE (In years last birthday)
93 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | | IF UNDER 24 HRS
HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Hungary | | | | 7b. CITIZEN OF WHAT COUNTRY?
Natural U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery | | | | | | | | Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Fairland NRS Hwy Fairland Rd - Silver Spring | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Maitre'd | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | | | 13c. CITY OR TOWN
SILVER SPRING | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
407 SHERBROOK DRIVE | | | | | | | | | | | |
| 14. FATHER'S NAME
IGNATIUS | | | | 15. MOTHER'S MAIDEN NAME
FANNIE | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, (no, or unknown) NO (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
565-12-8708 | | | | 17. INFORMANT
FREDERIC D. VECHERY | | | | | | | | Address
SAME AS # 13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 486X Pulmonary edema & Congestive failure.
DUE TO, OR AS A CONSEQUENCE OF Failure.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pneumonia, acute, bilateral
DUE TO, OR AS A CONSEQUENCE OF 12 days
(c) 1 day | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
490X acute cerebral hemorrhage (CVA) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-2-1968 , to 12-19-1968 , that (I) (we) last saw the deceased alive on 12-19-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John R. Spencer, M.D. | | | | DEGREE
M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-19-68 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
JOHN R. SPENCER, M. D. | | | | 22e. ADDRESS
15444 COLUMBIA ROAD, BERTONSVILLE, MD. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE
12-23-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
FT LINCLON CEMETERY | | | | 23d. LOCATION (City or Town) (County) (State)
BLADENSBURG MARYLAND. | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Francis Hall | | | | ADDRESS
390 University Blvd N. Silver Spring, Md. | | | | 25a. REC'D BY REGISTRAR
DEC 23 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Francis Hall | | | | | | | | | | | | | | | |

17883

UNITED STATES

UNITED STATES DEPARTMENT OF THE INTERIOR

UNITED STATES DEPARTMENT OF THE INTERIOR

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UNITED STATES DEPARTMENT OF THE INTERIOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17990

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17990

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) MABEL | | | First Middle Last MCKIM VEIHMAYER | | | 2a. DATE OF DEATH
12 Month 28 Day 68 Year | | | 2b. HOUR
1:55 A M | | | | | |
| 3. SEX
FEMALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
11-26-86 | | | 6. AGE (In years last birthday)
82 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
D. C. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
FAIRLAND NURSING HOME | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEKEEPER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | | 13b. COUNTY
MONT | | | 13c. CITY OR TOWN
SILVER SPRING | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
14221 GEORGIA AVE | | |
| 14. FATHER'S NAME
JOSHUA | | | First Middle Last GIBSON | | | 15. MOTHER'S MAIDEN NAME
ANNIE B. MEAD | | | First Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
213-54-8613 | | | 17. INFORMANT
NURSING HOME SUMMARY SHEET | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
471X IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 480X
(b) Influenza
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk
2 wks | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Generalized and Cerebral ARTERIOSCLEROSIS | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 1966 , to Dec 28, 1968 , that (I) (we) last saw the deceased alive on Dec 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Raymond T. Benack MD | | | | | | DEGREE
MD | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
12/28/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Raymond T. Benack MD | | | | | | 22e. ADDRESS
4115 Colie DR. Wheaton, Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
12/31/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Mar land | | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home | | | | | | ADDRESS
1331 Rock. Pike | | | 25a. REC'D BY REGISTRAR
JAN 3 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |
| | | | | | | DATE
Rockville, Md. | | | | | | | | |

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Journal Gibson Anne B. Merz

[illegible]

February 1969

RESULTS

Index

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|---|--|--|
| Item 5 Film 408 1/13/69 kk | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Galina (NMN) Volkov | | | | | | 2a. DATE OF DEATH
Month Day Year
December 27 1968 | | | 2b. HOUR
1:50 P | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
1927
26 January 1927 | | 6. AGE (In years last birthday)
41 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
11 1 | | IF UNDER 24 HRS.
HOURS MIN.
11 1 | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission, STATE)
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6301 Crathie Lane | | |
| 14. FATHER'S NAME First Middle Last
Vladimir Tzvetckoff | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Elizabeth (Unknown) | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or (unknown) <input checked="" type="checkbox"/> No | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Records Address
The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hodgkin's Disease involving lymph nodes, heart/
201X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
201X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (X) (this hospital) attended the deceased from 25 Dec., 1968, to 27 Dec., 1968, that (X) (we) last saw the deceased alive on 27 December 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Ervin H. Epstein, MD. | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
27 December 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Ervin H. Epstein, MD. | | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
12-30-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | | | | | |
| 24. FUNERAL DIRECTOR
H. J. Disconsiglio | | ADDRESS
Bethesda, Md. | | 25a. REC'D BY REGISTRAR
JAN 6 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

13281

CLARK'S BATH



[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. Some words like "CLARK'S BATH" and "13281" are visible.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | |
|---|--------------------------|---|--|---|
| 1. DECEASED-NAME
(Type or Print) MARY First ELIZABETH Middle WALLING Last | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 4 Year 1968 | | 2b. HOUR 10:15 AM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH May 3, 1896 | 6. AGE (In years last birthday) 72 YRS. | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH MONTGOMERY |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) housewife |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Mont. | 13c. CITY OR TOWN SIL.SPR. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME First Sam Cook Middle Last | | 15. MOTHER'S MAIDEN NAME First Cora Hardy Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 577 09 9706 | | 17. INFORMANT Son ADDRESS Thomas Walling, 406 Branch Rd. V&A Va |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE Belden R. Reap | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED DEC. 4 1968 |
| EXAMINER'S NAME (Type) BELDEN R. REAP M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (City, Town, or County) Washington |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12/7/68 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Memo. Park Cem. Fairfax, Virginia | | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR De Vol Funeral Home | | 25a. REC'D BY REGISTRAR DEC 11 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

6701-12-020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| 17982 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 17993 | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------------------------|--|--|--|--|-------------------|--|--|--|--|-------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First
John | | | | | Middle
J. | | | | | Last
WALSH, SR. | | | | | 2a. DATE OF DEATH
Month
December | | | | | Day
10 | | | | | Year
68 | | | | | 2b. HOUR
1000 | | | | |
| 3. SEX
Male | | | | | 4. RACE
Caucasian | | | | | 5. DATE OF BIRTH
31 May 1895 | | | | | 6. AGE (In years last birthday)
73 YRS. | | | | | IF UNDER 1 YEAR
MONTHS
 | | | | | IF UNDER 24 HRS.
DAYS
 | | | | | HOURS
 | | | | | MIN.
 | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Massachusetts | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U. S. Navy | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | | 13b. COUNTY
Pr. George | | | | | 13c. CITY OR TOWN
Adelphi | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER
10121 Towhee Ave. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
 | | | | | Middle
 | | | | | Last
 | | | | | 15. MOTHER'S MAIDEN NAME
First
 | | | | | Middle
 | | | | | Last
 | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/>
Yes | | | | | 16b. SOCIAL SECURITY NO.
1912-52 | | | | | 17. INFORMANT
Adelphia | | | | | Address
Md. | | | | | 17. INFORMANT
Mr. John J. Walsh, Jr., 10121 Towhee Ave. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
PNEUMONIA RIGHT LOWER LOBE
481X
IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
 | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
490X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from Dec. 8 , 19 68 , to Dec. 10 , 19 68 , that he (we) last saw the deceased alive on Dec. 10 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
A. L. Graybiel | | | | | | | | | | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
December 11, 1968 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
A. L. GRAYBIEL | | | | | | | | | | | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE
12/13/68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem. | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Arlington Va. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Timothy Hanlow Funeral Home | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE
DEC 16 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | | | | | | | | | | | | | | | | | | | |
| 4748 Wisconsin Ave., N.W. Washington, D. C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | |
|---|--|--|--------|---|-------------------------------------|--|--|--------------------------------|--|
| HERBERT | | E. | | WALTER | Dec 28 1968 | | | 6 ⁰⁰ A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| male | | white | | 11/25/92 | | 76 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| West DC | | USA | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | Suburban Hospital | | RETIRED | | N/A | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| West DC | | — | | D.C. | | | | 5437 COUN. AVE, N.W. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| John L. Walter | | Emma S. Parsons | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| Yes | | Army NW 577-01-8400 | | Sister Edna Walter Same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial Decomp with pulmonary | | | | | | | | | |
| 492X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Pulmonary emphysema, very severe 10YRS+ | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Uremia secondary to (a) and arteriosclerosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1958, to Dec 28, 1968, that (I) (we) last saw the deceased alive on Dec 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Stewart Clapp M.D. | | | | | | 12/27/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Stewart Clapp M.D. | | 5415 W Cedar Lane Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 12/31/68 | | CEDAR HILL CEMETERY | | SUITLAND, MD. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| JOS. GAWLER'S SONS, 5130 WIS. AVE, NW, WASH., D.C. | | | | DATE JAN 2 1969 | | J. Charles Judge | | | |

MEDICAL CERTIFICATION

17891

RECEIVED BY THE DIRECTOR OF THE
BUREAU OF THE LAND OFFICE
WASHINGTON, D. C.

RECEIVED BY THE DIRECTOR OF THE
BUREAU OF THE LAND OFFICE
WASHINGTON, D. C.

17891



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|---|--|--|---|--|--|--|--|--|
| <div> <div>17984</div> <div>Item 6 Film 0408 1/2/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>17995</div> </div> | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Mary | | | Middle
G. | | | Last
WALTERS | | | 2a. DATE OF DEATH
Dec. Month 18 Day Year 68 | | | 2b. HOUR
946P M | | |
| 3. SEX
Female | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
Apr. 29, 1915 | | | 6. AGE (In years last birthday)
53 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Secretary | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Rockville | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
816 Veirs Mill Road | | | | | |
| 14. FATHER'S NAME
First
William | | | Middle
Francis | | | Last
Gettings | | | 15. MOTHER'S MAIDEN NAME
First
Lillian | | | Middle
McGaha | | | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
577-26-3213 | | | 17. INFORMANT
Rockville | | | Address
Md. | | | 17. INFORMANT
William F. Walters 816 Veirs Mill Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid and intraventricular hemorrhage
4309
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
330X | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 27 , 19 68 , to Dec. 18 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 18 , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John P. Wissinger, M.D. | | | DEGREE
M.D. | | | ATTENDING PHYS.
<input type="checkbox"/> | | | MED. DIRECTOR
<input type="checkbox"/> | | | STAFF PHYS.
<input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
Dec. 19, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
John P. Wissinger, M. D. | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
12/23/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
ParkLawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Montgomery Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey
Funeral Home, 7557 Wisconsin Ave. Bethesda, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 26 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | |

1322

EXHIBIT OF 2-11

U. S. DEPARTMENT OF JUSTICE

Washington, D. C. 20535

February 11, 1968

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Re: [illegible]

Very truly yours,

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV 10

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|------------------------------|--|--|---------------------------|---|---------------------------------|---|---|--|------------------|--|
| 17985 | | | | | 17996 | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | |
| Last Warner; V. First Esther | | | | | Month 12 Day 26 Year 1968 | | | | | 3 45 A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | white | | 8/15/197 | | | 71 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Wash., D.C. | | U.S.A. | | | | Montgomery County Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | | Holy Cross Hospital | | | Clerk | | | U.S. Gov't. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | Montgomery | | | Sil.Spr. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 735 Sligo Avenue | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| Louis -- Oriani | | | Maria -- Cuneo | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | |
| No No -- | | | 578-36-8813 | | | Address Wash., D.C. Victoria Hiser 1315 Missouri Avenue, N.W. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Carcinoma of Lung | | | | | | | | | | few months | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 163X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/7, 1968, to 12/25, 1968, that (I) (we) lost the deceased alive on 12/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| G. Lennard Gold, M.D. | | | | | | | | | | 12/26/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | | |
| G. Lennard Gold, M.D. | | | | | | 9801 Georgia Avenue, Sil. Spr., Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 12-30-1968 | | | Cedar Hill Cemetery | | | Suitland Pr. Geos. Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| J. W. Lee Jr. Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | | | | | DATE JAN 3 1969 | | | J. Charles Judge | | | |

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
30M REV 1-68

17996

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17997

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <u>Martha U. WARREN</u> | | | 2a. DATE OF DEATH
Month <u>December</u> Day <u>1</u> Year <u>1968</u> | | | 2b. HOUR
<u>6:15 AM</u> | | | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>CAUC.</u> | | 5. DATE OF BIRTH
<u>Sept. 21 1880</u> | | 6. AGE (In years last birthday)
<u>88</u> YRS. | | IF UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> | | IF UNDER 24 HRS.
HOURS <u> </u> MIN. <u> </u> | |
| 7a. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Bethesda</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>GROSVENER LANE NURSING HOME</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>own home</u> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md.</u> | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Silver Spring</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>9302 Worth Ave.</u> | | | |
| 14. FATHER'S NAME
First <u>JAMES</u> Middle <u>J.</u> Last <u>CRABTREE</u> | | | 15. MOTHER'S MAIDEN NAME
First <u>Hannah</u> Middle <u>J.</u> Last <u>MOORE</u> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) <u>--</u> | | | 16b. SOCIAL SECURITY NO.
<u>227-05-5371</u> | | 17. INFORMANT
Address <u>John E. Hawk 808 Hobbs Drive, Sil. Spr., Md.</u> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u>
<u>4129</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4221</u>
(b) <u>generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u> </u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
<u>years</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Sensibility severe cellulitis & decubiti moderate</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>68</u> , to <u>Dec. 1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 30</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Wilfred R. Ehrmantraut MD</u> | | | | DEGREE
<u>MD</u> | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/1/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Wilfred R. Ehrmantraut</u> | | | | 22e. ADDRESS
<u>11125 Rockville Pk. Rockville Md</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>12-3-1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Colesville Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Montgomery Maryland</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc.</u> | | | | ADDRESS
<u>Sil. Spr. Md. 8434 Georgia Avenue</u> | | 25a. REC'D BY REGISTRAR
DATE <u>DEC 6 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|-----------------------------------|---------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Sadie Elizabeth | | | Warren | | | Dec Month 30 Day 1968 Year | | | 12.02 M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | Negro | | 6/29/1877 | | 91 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | | |
| Md. | | USA | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Wheaton | | | University Nursing Home | | | house wife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| DC. | | | 1 | | | Washington | | YES | | 4624 New Hampshire Avenue | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| no | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis | | | | | | | | | | | |
| 4339 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) Generalized Arteriosclerosis | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 332X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/27, 1968, to 12/29, 1968, that (I) (we) last saw the deceased alive on 12/29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Pedro I. Matias M.D. | | | | | | | | | | | 22c. DATE SIGNED 12/30/68 |
| 22d. PHYSICIAN'S NAME (Type) PEDRO I. MATIAS, M.D. | | | | | | | | | | | 22e. ADDRESS 47th Montgomery PL Beltsville Md |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 1-4-69 | | Church cemetery | | Montgomery | | County | | State | |
| 24. FUNERAL DIRECTOR John D. Watson 3435-14 St. NW | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 31 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1-1-68

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 17998 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 17999 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>CHARLES L. WASHINGTON</i> | | | 2a. DATE OF DEATH
Month <i>Dec.</i> Day <i>29</i> Year <i>1968</i> | | | 2b. HOUR
<i>11:29</i> M | |
| 3. SEX
<i>MALE</i> | | 4. RACE
<i>NEGRO</i> | | 5. DATE OF BIRTH
<i>7/06/09</i> | | 6. AGE (In years last birthday)
<i>59</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Montgomery</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Montgomery</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Laborer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>GERMANTOWN</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>Rt 118</i> | | 14. FATHER'S NAME
First <i>HEZIKAH</i> Middle <i>Washington</i> Last <i>Washington</i> | | 15. MOTHER'S MAIDEN NAME
First <i>Lila</i> Middle <i>Fairfax</i> Last <i>Fairfax</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>518-22-7404</i> | | 17. INFORMANT
<i>Gladys Washington, wife, German town</i> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Coronary Occlusion</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Atherosclerotic C-V Dis.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1964</i>
<i>1962</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>No</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct.</i> , 19 <i>62</i> to <i>12-29</i> , 19 <i>68</i> , that (I) (we) las saw the deceased alive on <i>Nov.</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Clive E. Jackson, M.D.</i> | | | | 22c. DATE SIGNED
<i>12-30-68</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>202 Martin Ln, Rockville, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>1-2-1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Brooke Grove Cem</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Laytonville Montgo. Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Robert L. Snowden Rockville Md.</i> | | | | 25a. REC'D BY REGISTRAR
<i>JAN 3 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

17882

INSTITUTE OF DEATH

1963

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|-------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) MARIE | | | First A. Middle WATERS Last | | | 2a. DATE OF DEATH
DEC Month 14 Day 68 Year | | | 2b. HOUR
1145P M | | | | | | | | |
| 3. SEX
Female | | | 4. RACE
NEGROID | | | 5. DATE OF BIRTH
17 DEC 1915 | | | 6. AGE (In years last birthday)
52 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
VA | | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
NAVAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY
At home | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | | 13b. COUNTY
WASHINGTON | | | 13c. CITY OR TOWN
WASHINGTON | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
1320 MISSISSIPPI AVE., S.E. | | | | | |
| 14. FATHER'S NAME
WILLIAM T. BETTS | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
MARY E. EVANS | | | First Middle Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
214-22-9707 | | | 17. INFORMANT
MR. HERBERT WATERS, 1320 MISS. AVE., S.E. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CANCER OF LEFT BREAST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 DEC 68 , 19 68 , to 14 DEC , 19 68 , that (I) (we) last saw the deceased alive on 14 DEC , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Donald Roeder | | | DEGREE
MD. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
15 DEC 68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
DONALD ROEDER, MD. (LCDR MC USN) | | | 22e. ADDRESS
NAVAL HOSPITAL, BETHESDA, MARYLAND | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
12-19-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
National Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
Randolph Collick, 2431 E. Oliver St., Balt., Md. | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DEC 18 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | 18001 | | | |
|--|-------------------------|---|--|---|---|---|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) <i>DEWEY</i> | | | First Middle Last <i>WATKINS</i> | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 12 12 1968 | | | 2b. HOUR
9:30 P.M. | | | | |
| 3. SEX
<i>male</i> | 4. RACE
<i>white</i> | 5. DATE OF BIRTH
<i>Jan 28-1904</i> | 6. AGE (in years
last birthday)
<i>70</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year <i>Dec 12 1968</i> | | 2d. HOUR
<i>10:30 P.M.</i> | | | |
| 7a. BIRTHPLACE (State or foreign
country) <i>Montg & Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital
give street address)
<i>Suburban Hospital</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>clerking</i> | | | 12b. KIND OF BUSINESS OR
INDUSTRY
<i>Retired</i> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Gaithersburg</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>18529 Strawberry Rd.</i> | | | | |
| 14. FATHER'S NAME First Middle Last
<i>Eldridge Watkins</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Emma Burton</i> | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS
<i>Hellie Mullins, 701 any sub</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Smoke inhalation and burns, diffuse, 40%</i>
<i>890X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>9160</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
<i>9:30 P.M. Dec-12-1968</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<i>Trapped in house fire</i> | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
<i>Home</i> | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<i>18529 Strawberry Rd. Gaithersburg Mont. Md</i> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE <i>John B Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
<i>Dec. 13, 1968</i> | | | | | | | |
| EXAMINER'S
NAME (Type) | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<i>burial</i> | | | 23b. DATE
<i>12-16-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Forest Oak</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Gaithersburg Montg Md</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Ernest C. Gartner</i> | | | ADDRESS
<i>Gaithersburg. Md</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>DEC 19 1968</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | |

1803

929 91 030

100-100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 17991 | | | | | | | | | | |
| 18002 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Lost
Catherine Irene Watts | | | 2a. DATE OF DEATH
Month Day Year
12 20 68 | | 2b. HOUR
11:30 A.M. | | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
6/22/1887 | | 6. AGE (In years
lost birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton, | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
University Nurs. Home | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Domestic | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived,
if institution: Residence before
admission) STATE
Wash., DC | | | 13b. COUNTY
V | | 13c. CITY OR TOWN
Wash., DC | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
24 Bryant St., NW | |
| 14. FATHER'S NAME
First Middle Lost
William Osborne | | | 15. MOTHER'S MAIDEN NAME
First Middle Lost
Cornelia Barner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
577-24-2413 | | 17. INFORMANT
Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>
4120 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a).
(b) <i>Myocardial infarction</i>
stating the underlying cause
last: 443X DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Generalized arteriosclerosis</i> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 month
5 yrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Diabetes mellitus - Left Heart Failure</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/1/68</i> , 19 <i>68</i> , to <i>12/20/68</i> , 19 <i>68</i> , that (I) (we) last
saw the deceased alive on <i>12/20/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Edward Mazique</i> | | | | | DEGREE
ATTENDING
PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12/20/68 | |
| 22d. PHYSICIAN'S
NAME (Type)
Edward Mazique, MD | | | | | 22e. ADDRESS
1801 9th St., NW, Wash., DC | | | | | |
| 23a. (BURIAL) CREMATION,
REMOVAL (Specify) | | 23b. DATE
12-24-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Mem. | | 23d. LOCATION (City or Town),
(County) (State)
Baltimore, Md | | | | |
| 24. FUNERAL DIRECTOR
<i>Frozen Funeral Home R. Jan</i> | | | ADDRESS
589 | | 25a. REC'D BY REGISTRAR
DATE
DEC 27 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | | | |

18003

RECEIVED



RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17902

CERTIFICATE OF DEATH

18003

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) ANNETTE | | | First Middle Last | | | 2a. DATE OF DEATH
Month 12 Day 4 Year 68 | | | 2b. HOUR
2:21 P.M. | | |
| 3. SEX
FEMALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
6-5-15 | | | 6. AGE (In years last birthday)
53 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
MD | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY County Md. | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING, MD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | | 13b. COUNTY
MONTGOMERY | | | 13c. CITY OR TOWN
SILVER SPRING | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
SAMUEL | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
KAY | | | First Middle Last
MERICAN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
NO | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
213-103928 | | | 17. INFORMANT
HELEN WEINER Address SAME AS 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) CEREBRAL THROMBOSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIO SCLEROSIS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 HRS.
3 DAYS
1-2 YRS. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
332X NONE | | | | | | | | | | | |
| 19a. DATE OF OPERATION
NONE | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1/68 , to 12/4/68 , that (I) (we) last saw the deceased alive on 12/4/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harold Steadman | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
12/4/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
HAROLD STEADMAN, MD | | | | | | 22e. ADDRESS
1352 UNIV. BLVD. EAD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
12-6-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
BETH BAR ABRAHAMSON OF BALTIMORE | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE MD | | |
| 24. FUNERAL DIRECTOR
Medley Funeral Home 42179 AR. AVE | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DATE DEC 5 1968 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
James Judge | | | | | |

18003

STATE OF TEXAS

IN SENATE, FEBRUARY 1, 1903.

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

FOR THE YEAR

ENDING DECEMBER

31, 1902.

BY

JOHN W. HARRIS,

COMMISSIONER.

RECEIVED

DECEMBER 1, 1902.

AT THE

OFFICE OF THE

COMMISSIONER

OF THE

LAND OFFICE

AT DALLAS,

TEXAS.

1903.

PRINTED

BY

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17993 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18004 | |
|--|--|--|--|--|--|--|--|--|---|---|--|-------------------------|--|--|--|--|--|--|--|----------|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | |
| BERTHA COLLIER WEINSTEIN | | | | | | | | | | 12-5-68 | | | | | | | | | | 7:45 PM | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | |
| Female | | | White | | | 6-11-96 | | | 72 YRS. | | | MONTHS DAYS HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | |
| Mass. | | | USA | | | | | | Montgomery | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| Takoma Park, | | | Wash. San. & Hosp. | | | Housewife | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Md. | | | Mont. Co. | | | Silver Spring | | | | | | 8250 New Hampshire Ave. | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | |
| Isador Aaronson | | | | | Flora Bräitstein | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | | | |
| None | | | | | | | | | | Mrs. Sylvia Davis, as above | | | | | Dtr. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | | | | | | 4 HRS. | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | |
| (b) CORONARY ATHEROSCLEROSIS | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | | | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION | | | | | Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG, 1968, to 12-5, 1968, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | |
| Myron L. Lanken MD | | | | | | | | | | 12-5-68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | | | | 12/8/68 | | | | | Mt. Lebanon Cemetery | | | | | Hyattsville, Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Bernard Danzansky & Sons | | | | | | | | | | 3501 14th St Wash., D.C. | | | | | DEC 11 1968 | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 17994 | | | | | | | | | |
| 18005 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Maryanne | | | Claudine Wells | | | Dec 22 Month Day Year 68 | | | M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR |
| F | | W | | April 6, 1876 | | | 92 YRS. | | MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Pennsylvania | | U.S.A. | | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Gaithersburg | | | Asbury Methodist Home | | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| Virginia | | | | | Arlington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4201-13th Street, South |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last Samuel Byerly | | | First Middle Last Mary Ann Byerly | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| no | | | 218-54-9127 | | Asbury Methodist Home, Gaithersburg, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Generalized Atherosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 DAY
20 YRS. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/18/64</u> , 19 <u>64</u> , to <u>12/22/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/22/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Henry C. Scruggs</u> | | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/22/68</u> |
| 22d. PHYSICIAN'S NAME (Type)
Henry C. Scruggs | | | | | 22e. ADDRESS | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 12-27-68 | | Tioga Point | | Athens, Penn Pa | | | |
| 24. FUNERAL DIRECTOR
<u>Ernest C. Gartner</u> | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 27 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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17995

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18006

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print)
First Middle Last
ATala IRENE Wendell | | | 2a. DATE OF DEATH
Month Day Year
12 19 68 | | | 2b. HOUR
11 P M | |
| 3. SEX
Female | | 4. RACE
WHITE | | 5. DATE OF BIRTH
Feb. 18, 1888 | | 6. AGE (In years last birthday)
80 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Cann | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Potomac Valley Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
R.N. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. COUNTY
AR | | 13c. CITY OR TOWN
WASH. D.C. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
3901 ARGYLE ST. NW | | 14. FATHER'S NAME
First Middle Last
JOHN PETTER WHALEY | | 15. MOTHER'S MAIDEN NAME
First Middle Last
MARY BORRAWS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
043-280424 | | 17. INFORMANT
(SON) Wm. D. WENDEL JR. | | Address
3901 ARGYLE ST. NW WASH. D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
5990
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 609X
(b) Urinary Infection
DUE TO, OR AS A CONSEQUENCE OF
(c) ? | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)
ASHD, CVA Gen. arteriosclerosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 Dec , 19 68 , to 19 Dec , 19 68 , that (I) (we) last saw the deceased alive on 19 Dec , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John S. Soia MD | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type)
John S. Soia | | | | 22e. ADDRESS
807 Viers Mill Rd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
cremation | | 23b. DATE
12-21-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Coleman Manor Md | |
| 24. FUNERAL DIRECTOR
W. W. Chamber C | | | | ADDRESS
1400 Cayin St. N.W. Wash. D.C. | | 25a. RECD BY REGISTRAR
DATE
DEC 31 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

| 17996 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | CERTIFICATE OF DEATH | | | | 18007 | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>MARY CATHERINE WERLE</i> | | | | | | 2a. DATE OF DEATH
<i>12</i> Month <i>28</i> Day <i>68</i> Year | | | | 2b. HOUR
<i>6:35</i> P.M. | | | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>CAUC.</i> | | 5. DATE OF BIRTH
<i>JAN. 7. 1879</i> | | 6. AGE (In years
last birthday)
<i>89</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign
country) <i>WASH. D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>MONTGOMERY</i> Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>FAIRLAND</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>FAIRLAND NURSING HOME</i> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>WASH. D.C.</i> | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>WASH. D.C.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>1635 WEBSTER ST. N-E</i> | | | | | |
| 14. FATHER'S NAME
First <i>AUGUST</i> Middle <i>NEFF</i> Last | | 15. MOTHER'S MAIDEN NAME
First <i>Julia</i> Middle <i>Brooke</i> Last | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>—</i> | | 16b. SOCIAL SECURITY NO.
<i>216-16-4372</i> | | 17. INFORMANT
Address <i>FROM MEDICAL RECORD.</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Heart failure</i>
<i>4379</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>Generalized & cerebral arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized debilitation & advanced age</i>
(c) <i>1-2 days</i> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>1-2 days</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>334X Chronic hypochromic anemia</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-15</i> , 19 <i>63</i> , to <i>12-28</i> , 19 <i>68</i> , that (I) (we) lost
saw the deceased alive on <i>12-28</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>John R. Spencer, MD</i> | | 22c. DATE SIGNED
<i>12-28-68</i> | | 22d. PHYSICIAN'S
NAME (Type) <i>John R. Spencer</i> | | 22e. ADDRESS
<i>BURTONSVILLE, MD</i> | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>12-31-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Olivet</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Washington, D. C.</i> | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Francis J. Collins</i> | | 25a. REC'D BY REGISTRAR
DATE <i>JAN 3 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 17997 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18008 | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|---|--|---|--|-----------------|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>MARGARET R. Whitcomb</i> | | | | | First Middle Last | | | | | 2a. DATE OF DEATH
Month Day Year <i>12-14-68</i> | | | | | 2b. HOUR
<i>10:40 A</i> | | | | | | | | | |
| 3. SEX
<i>FEMALE</i> | | | 4. RACE
<i>WHITE</i> | | | 5. DATE OF BIRTH
<i>1-25-1876</i> | | | | | 6. AGE (In years
last birthday)
<i>92 YRS.</i> | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | IF UNDER 24 HRS | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
<i>Wash. D.C.</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>MONTGOMERY</i> Md. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>KENSINGTON</i> | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital,
give street address)
<i>NURSING HOME
KENSINGTON GARDENS</i> | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
<i>Housewife</i> | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
<i>own home</i> | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
<i>MD</i> | | | | | 13b. COUNTY
<i>MONTGOMERY</i> | | | | | 13c. CITY OR TOWN
<i>TAPOMA</i> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
<i>7777 MAPLE AVE.</i> | | | | | | | | |
| 14. FATHER'S NAME
<i>BENJAMIN - - - ELLIN</i> | | | | | First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME
<i>FLORENCE - - - RIGGLES</i> | | | | | First Middle Last | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>No</i> | | | | | 16b. SOCIAL SECURITY NO.
<i>220-46-9441</i> | | | | | 17. INFORMANT
Address <i>S.S. 2nd</i>
<i>Edwin Whitcomb-8409 BURNING WOOD</i> | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i>
<i>4129</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>advanced arteriosclerotic heart disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 hrs.</i>
<i>2 1/2 yrs.</i> | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>420K cerebral vascular accident with rt. hemiplegia 11/12/68</i> | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 18, 1966</i> , to <i>Dec 14, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>D.B. Washington M.D.</i> | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
<i>12/14/68</i> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>D.B. Washington M.D.</i> | | | | | | | | | | 22e. ADDRESS
<i>5802 Ridgefield Rd Bethesda Md 20016</i> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | | 23b. DATE
<i>12-16-68</i> | | | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rock Creek Cemetery</i> | | | | | 23d. LOCATION (City or Town) (County) (State)
<i>Washington D.C.</i> | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>M. Andrew Duval Warner E. Humphrey Inc.</i> | | | | | | | | | | ADDRESS
<i>8434 Ga. Ave. S.S., Md</i> | | | | | 25a. REC'D BY REGISTRAR
<i>DEC 19 1968</i> | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | |

80081

ORIGINAL OF COPY

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80081

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

179998

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18009

| | | | | | | | | | | | | | |
|--|--|---------------------------|---|--|--|--|--|---|--|---|-----------------------------------|---|--|
| 1. DECEASED-NAME (Type or Print) <u>Carl</u> First <u>Estlin</u> Middle <u>White</u> Last | | | | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 12/7 1968 | | | 2b. HOUR 3:30 P.M. | | | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH <u>5/22/17</u> | | 6. AGE (In years last birthday) <u>51</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) <u>Wash DC</u> | | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | | | | |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>DC</u> | | | | 13b. COUNTY <u>Washington</u> | | | | 13c. CITY OR TOWN <u>Washington</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>1745 Upshur St N.W.</u> | |
| 14. FATHER'S NAME First <u>Leroy</u> Middle <u>T</u> Last <u>White</u> | | | | | | 15. MOTHER'S MAIDEN NAME First <u>Anne</u> Middle <u>E</u> Last <u>Estlin</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs Anne Estlin</u> | | | | ADDRESS <u>Rock Beach Md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction Acute.</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u>
(b) <u>Thrombosis Coronary Artery</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Recent</u>
<u>Recent</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <u>19</u> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John S. Ball</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>Dec. 8, 1968.</u> | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>12/10/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem.</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Friendship Md</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Hutchins Funeral Home</u> | | | | | | ADDRESS <u>Owings, Md</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 13 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u> | | | |

18003

RECEIVED BY THE OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315

DATE 10/25/50
TIME 10:10 AM

100-13000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17998

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18010

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print)
First Middle Last
MARCUS ALVIN WHITE | | | 2a. DATE OF DEATH
Month Day Year
DECEMBER 21 1968 | | | 2b. HOUR
9:45 P. M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
2/24/34 | | 6. AGE (In years last birthday)
34 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Draft Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Private | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | 13b. COUNTY
HOWARD | | 13c. CITY OR TOWN
WOODBINE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
RFD #2 | | 14. FATHER'S NAME
First Middle Last
Malvin Maxwell White | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mamie Lillian Hale | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO.
577-44-9977 | | 17. INFORMANT
Hospital Records | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Failure
171.2
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Fibrosarcoma
DUE TO, OR AS A CONSEQUENCE OF
(c) Fibrosarcoma, Right arm | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days
3 1/2 yrs
5 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
1972 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 1968 , to 12/21, 1968 , that (I) (we) last saw the deceased alive on 12/21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
G. Leonard Gold | | 22c. DATE SIGNED
12/21/68 | | 22d. PHYSICIAN'S NAME (Type)
G. Leonard Gold | | 22e. ADDRESS
Silver Spring - Md | |
| 23a. BURIAL, CREMATION, REINTERMENT
Buried | | 23b. DATE
Dec. 24 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Grove | | 23d. LOCATION (City or Town) (County) (State)
Glenwood Howard Md. | |
| 24. FUNERAL DIRECTOR
Francis H. Barber | | ADDRESS
Laytensville Md | | 25a. REC'D BY REGISTRAR
DEC 26 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

MEDICAL CERTIFICATION

01081

(M)

During the 21 days of the

March 11, 1968

at the

March 11, 1968

March 11, 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE MARYLAND b. COUNTY MONTG. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA | |
| c. LENGTH OF STAY IN lb
YRS. | | d. STREET ADDRESS
5709 LONE OAK DR. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
5709 LONE OAK DR. | | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
EDNA TOPHAM WHITTET | | 4. DATE OF DEATH
Month Day Year
12 - 28 - 1968 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
DEC. 29, 1890 |
| 9. AGE (In years last birthday)
77 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
AT HOME | 11. BIRTHPLACE (County & State, or foreign country)
WASH. D.C. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
GEORGE TOPHAM | |
| 14. MOTHER'S MAIDEN NAME
MARGARET REESE SOUTHERLAND | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | |
| 16. SOCIAL SECURITY NO.
214-52-4028 | | 17. INFORMANT
Address
DAVID S. WHITTET - ANNANDALE, VA. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary heart disease with myocardial infarction
2509 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Generalized arteriosclerosis
DUE TO
(c) Diabetes mellitus | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs.
15+ years
25 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
260x | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 1963 to Dec. 28, 1968 that (I) (we) last saw the deceased alive on Dec. 21, 1968 , and that death occurred at 7:50 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Richard M. Huffman | | 22b. DATE SIGNED
12/28/68 | |
| 22c. PHYSICIAN'S NAME (Type)
RICHARD M. HUFFMAN, M.D. | | 22d. ADDRESS
2001 EYE ST. N.W. WASH., D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
12/31/68 | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEM. | 23d. LOCATION (City, town or county) (State)
SUITLAND, MD. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
JOS. GAWLER'S SONS, 5130 WIS. AVE., WASH., D.C. | | 25. REC'D BY REGISTRAR
JAN 3 1969 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

THE CHURCH OF THE HOLY TRINITY, NEW YORK, N.Y.

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CHURCH OF THE HOLY TRINITY, NEW YORK, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11)
30M REV. 11-68

| 18001 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18012 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|-----------------------------|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| James H. Widner | | | | | | | | | | Month 12 Day 19 Year 1968 | | | | | 11 30 AM | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| Male | | | white | | | March 13, 1919 | | | 49 YRS. | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Hawaii | | | U.S.A. | | | | | | Montgomery Md | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| Silver Spring | | | Holy Cross Hospital | | | Contractor | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| Maryland | | | Montgomery | | | Silver Spring | | | YES | | | 508 DENNIS AVENUE | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | | | | | | | | | | | | | | | | | | | |
| ELIGA S. WIDNER | | | | | | ROSE SHOWERS | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | | | | | | | | | | | | | |
| YES | | | WORLD WAR II | | | 577-10-0779 | | | Bernice C. Widner | | | Same as #13 | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiac Hemorrhage.</u> | | | | | | | | | | 4 days | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 331X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1958, to <u>12-19</u> , 1968, that (I) (we) last saw the deceased alive on <u>12-18</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Meruch T. Kimble, M.D.</u> M.D. DEGREE | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED <u>12-19-1968</u> | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE, M.D.</u> | | | | | | | | | | 22e. ADDRESS <u>9801 Georgia Ave, Silver Spring, Md.</u> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 12-23-68 | | | | | Gate of Heaven Cem. | | | | | Silver Spring, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Thomas J. Collins</u> ADDRESS <u>500 University Blvd, Silver Spring, Md.</u> | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE <u>DEC 23 1968</u> | | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | | | | | | | | | | | | | | |

18613

STATE OF TEXAS

18613

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "State of Texas" and "County of..." are faintly visible.]

18002

CERTIFICATE OF DEATH

18013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15 Dr. Road
15 Medical Examiner
15 cleared to Medical Examiner

| | | | | | | | |
|---|--|---|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
FANNIE WIENER | | | 2a. DATE OF DEATH Month Day Year
12 30 68 | | | 2b. HOUR
2:15 PM | |
| 3. SEX
F | | 4. RACE
Cau | | 5. DATE OF BIRTH
Not Known | | 6. AGE (In years last birthday) YRS.
12 | |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
University of Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
11200 Lybost St. 11200 Lybost St. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 13e. STREET AND NUMBER
11200 Lybost St. | | 14. FATHER'S NAME First Middle Last
Morris Brodsky | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
No | | 17. INFORMANT Address
Milton Wiener - 3578 - Roger Ave. 85 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive + arteriosclerotic heart disease
4120 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
443X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 24, 1966 , to Dec 30 1968 , that (I) (we) last saw the deceased alive on Dec 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Boris Rabin | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
12-30-68 | |
| 22d. PHYSICIAN'S NAME (Type)
BORIS RABKIN MD | | | | 22e. ADDRESS
1019 Univ. Blvd. EOW | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
12/31/68 | | 23c. NAME OF CEMETERY OR CREMATORY
mt ararat Cem. | | 23d. LOCATION (City or Town) (County) (State)
Pine Lawn - Long Island, N.Y. | |
| 24. FUNERAL DIRECTOR
Bernard Manzanovsky | | | | ADDRESS
3501-14th | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| | | | | DATE
JAN 3 1969 | | 25b. REGISTRAR'S SIGNATURE | |

18013

RECEIVED

18013

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18003

18014

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|---|---|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
GENE BARBARA WILDER | | | 2a. DATE OF DEATH
Month Day Year
DECEMBER 11, 1968 | | | 2b. HOUR
5:40 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
JANUARY 3, 1922 | | 6. AGE (In years
last birthday)
46 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA, MARYLAND | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
U. S. NAVAL HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, not retired.)
LINGUIST (NSA) | | 12b. KIND OF BUSINESS OR
INDUSTRY
GOVERNMENT | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MARYLAND | | 13b. COUNTY
PRINCE GEORGE'S | | 13c. CITY OR TOWN
BELTSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4309 KENNY STREET | |
| 14. FATHER'S NAME First Middle Last
JOSEPH BURDYN | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ROSALEE GORCZYCA | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
236-20-8994 | | 17. INFORMANT (HUSBAND) 4309 KENNY STREET
STERLING H. WILDER BELTSVILLE, MARYLAND | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE INTRACEREBRAL HEMORRHAGE
431.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
331X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? YES | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
10:30 AM | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State
10:30 AM 5:40 PM | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 11, 1968 , to DECEMBER 11, 1968 , that <input checked="" type="checkbox"/> (we) last
saw the deceased alive on DECEMBER 11, 1968 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the
causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John A. Routenberg DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
DECEMBER 11, 1968 | | | |
| 22d. PHYSICIAN'S
NAME (Type) JOHN A. ROUTENBERG, LT MC USN | | | | | | 22e. ADDRESS
U.S. NAVAL HOSPITAL, BETHESDA, MD. | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
12/16/68 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
ARLINGTON, VIRGINIA | | | |
| 24. FUNERAL DIRECTOR NALLEY FUNERAL HOME ADDRESS
3200 RHODE ISLAND AVE., MT. RANIER, MD. | | | | | | 25a. REC'D BY REGISTRAR
DATE DEC 19 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1801

REPUBLIC OF CHINA

INDIA

BANGLA

GENE

FEMALE

CAUCASIAN

INDIAN

INDIAN

MILITARY

MILITARY

DETACHED, TAWAY AND

DETACHED, TAWAY AND

DETACHED, TAWAY AND

DETACHED, TAWAY AND

DETACHED, TAWAY AND

DETACHED, TAWAY AND

DETACHED, TAWAY AND

DETACHED, TAWAY AND

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NO

NO

YES

NO

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DETACHED, TAWAY AND

DETACHED, TAWAY AND

should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/80

| 18005 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 18016 | | | | | |
|--|--|--|--|--|--|--|--|------------------------|----------|--|--|
| 1. DECEASED-NAME (Type or print) | | | | First Middle Last | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Mollie | | | | E Wilkins | | Dec 18 1968 | | | 11:30 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | 5/18/88 | | 80 | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md | | |
| West VA | | U.S.A. | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | Suburban | | Housewife | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md | | Mont | | Boyd | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Aaron Halterman | | | | Shelton Cooper | | | | Halterman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| | | 220-26-495291 | | Arlean Wilkins Halterman Boyd | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AV dissociation - Cardiac arrest</u> | | | | | | | | | | 20 mins. | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> | | | | | | | | | | 6 days | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic heart disease</u> | | | | | | | | | | at least 1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>acute cholecystitis complicating above</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION - Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December 12, 1968</u> , to <u>December 18, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Frederick S. Caldwell M</u> DEGREE <u>MD</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED <u>12-18-68</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u>FREDERICK S CALDWELL</u> | | | | | | | | | | 22e. ADDRESS <u>ROCKVILLE, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 12-21-68 | | Dormstown Presbyterian | | Dormstown Mont Md | | | | | |
| 24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u> ADDRESS <u>Boyersburg, Pa.</u> | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>Arlean Wilkins</u> | |
| 25a. REC'D BY REGISTRAR <u>Arlean Wilkins</u> DATE <u>DEC 23 1968</u> | | | | | | | | | | | |

18016

CERTIFICATE OF DEATH

18016

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|---------------|--|------|--|-------|--|----------------|--|----------------|--|------------|--|----------------|--|----------------|--|---------------|--|---------------|--|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Date of Birth | | Sex | | Race | | Religion | | Marital Status | | Occupation | | Cause of Death | | Place of Death | | Date of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| John Doe | | 10/10/1900 | | Male | | White | | Roman Catholic | | Married | | Farmer | | Heart Disease | | Home | | 10/15/1950 | | 10:00 AM | | J. Smith | | A. Jones | | B. Brown | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--------------------------------------|--|--------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| Items#13c&13eFilm#G408 12/31/68 CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last | | | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
M | | | |
| Dea | | | | | mi Williams | | | DEC 14 68 | | | |
| 3. SEX
Female | | 4. RACE
Negroid | | 5. DATE OF BIRTH
12-25-1874 | | 6. AGE (In years last birthday)
93 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OR WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
DARNES TOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GREEN Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Darnestown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
none | | | |
| 14. FATHER'S NAME First Middle Last
Unknown | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u>
<u>4120</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Generalized Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>years</u>
<u>years</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>443X</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/19/68</u> , 19 <u>68</u> , to <u>14 Dec</u> , 19 <u>68</u> , that (I) was saw the deceased alive on <u>13 Dec</u> , 19 <u>68</u> , and that in (my) four opinion death occurred on the date and hour and from the causes stated above, (I) we did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Gordon M. Smith MD</u> | | DEGREE
MD | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>16 Dec 68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
Gordon M. Smith, MD | | 22e. ADDRESS
Boyd, Md 20720 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
12-19-68 | | 23c. NAME OF CEMETERY OR CREMATORY
ASH Memorial Cem. | | 23d. LOCATION (City or Town)
Savoy Spring Monty Md. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR
<u>Robert L Snowden Rockville Md</u> | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE
DEC 23 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | |

1001

1001

1001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When these remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18007 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 18018 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Norwood Clark Williams | | | | | | | | | | 12 Month 11 Day 68 Year | | | | | | | | | | 10:40 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| Male | | | | | | | | | | Negro | | | | | | | | | | 11/5/1900 | | | | | | | | | | 68 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Washington, D.C. | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Montgomery | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wheaton | | | | | | | | | | University Nursing Home | | | | | | | | | | Employee Gov. Print. Off. | | | | | | | | | | U.S. Gov. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| D.C. | | | | | | | | | | | | | | | | | | | | Washington | | | | | | | | | | | | | | | | | | | | 727 Shepherd St., N.W. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alonzo Williams | | | | | | | | | | Anna Clark | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | 579-42-7683 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Pulmonary and Cerebral metastases DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis primary from the pancreas. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 157X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| APRIL, 1968 | | | | | | | | | | CANCER OF PANCREAS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/28, 1968, to 12/11/68, that (I) (we) last saw the deceased alive on 12/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Pedro I. Matias M.D. | | | | | | | | | | 22c. DATE SIGNED 12/11/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) PEDRO I. MATIAS, M.D. | | | | | | | | | | 22e. ADDRESS 4712 Montgomery PLACE BELTSVILLE, Md. 20705 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE 12/16/1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Suitland, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Mr. Ernest Jarvis Co. 1432 1/2 North St. N.E. | | | | | | | | | | 25. REC'D BY REGISTRAR DEC 16 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|-----------------|--|---|--|---|--------------------------|------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | | | |
| Henry | | Valmont | Willoughby, III | | Month Day Year
December 4 1968 | | 8:15 P M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR | | 7. UNDER 24 HRS. | |
| Male | | White | | 27 April 1951 | | 17 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| District of Columbia | | USA | | | | Montgomery | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | The Clinical Center, NIH | | Student | | None | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| District of Columbia | | | | Washington | | | | 3705 Carpenter St., S.E. | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | | |
| Henry | | V. | Willoughby, II | | Clara | | | | Fagg | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | The Medical Record | | Address | | | |
| No | | Not available | | The Clinical Center, NIH, Bethesda, Maryland | | | | | | | |
| MEDICAL CERTIFICATION | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| | | IMMEDIATE CAUSE (a) <u>Septicemia</u> | | | | | | | | 5 days | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| MEDICAL CERTIFICATION | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>2040</u> | | | | | | | | 1 month | |
| | | (b) <u>Acute Lymphocytic Leukemia</u> | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | (c) | | | | | | | | | |
| MEDICAL CERTIFICATION | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| | | <u>Small bowel obstruction, intestinal bleeding, meningitis</u> | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>21 Nov.</u> , 19 <u>68</u> , to <u>4 Dec.</u> , 19 <u>68</u> , that (X) (we) lost the deceased alive on <u>4 December</u> , 19 <u>68</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | Richard J. Samaha MD | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| | | | | | | | | | December 5, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) | | Richard J. Samaha, M.D. | | | 22e. ADDRESS | | | | | | |
| | | | | | The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 7 Dec 68 | | Ft. Lincoln Cemetery | | Bladensburg, | | | | Md. | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Simmons Bros. | | Wash DC | | | DEC 6 1968 | | [Signature] | | | | |
| Simmons Bros 1661 Good Hope Rd SE | | | | | | | | | | | |

18013

18013

| Name | Address | City | State | Zip |
|-------------|---------|---------------|-------|-------|
| John | 1234 | New York | NY | 10001 |
| Mary | 5678 | Los Angeles | CA | 90001 |
| James | 9101 | Chicago | IL | 60601 |
| Patricia | 2345 | Houston | TX | 77001 |
| Robert | 6789 | Phoenix | AZ | 85001 |
| Linda | 1011 | San Antonio | TX | 78201 |
| Michael | 4567 | Dallas | TX | 75201 |
| Susan | 8901 | San Diego | CA | 92101 |
| David | 3456 | Austin | TX | 78701 |
| Jennifer | 7890 | Fort Worth | TX | 76101 |
| Christopher | 2109 | Jacksonville | FL | 32201 |
| Elizabeth | 5432 | Nashville | TN | 37201 |
| Daniel | 9876 | Portland | OR | 97201 |
| Michelle | 1357 | San Jose | CA | 95101 |
| Kevin | 6543 | San Francisco | CA | 94101 |
| Amanda | 0987 | Seattle | WA | 98101 |
| Jonathan | 4321 | Denver | CO | 80201 |
| Stephanie | 8765 | Boston | MA | 02101 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 180098 CERTIFICATE OF DEATH 18020 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
<i>Wink Anna</i> | | | First <i>ANNA</i> Middle <i>T</i> Last <i>WINK</i> | | | 2a. DATE OF DEATH
Month <i>Dec</i> Day <i>9</i> Year <i>1968</i> | | 2b. HOUR
<i>11:10 PM</i> | |
| 3. SEX
<i>Fe</i> | | 4. RACE
<i>wh</i> | | 5. DATE OF BIRTH
<i>MAY -21, 1907</i> | | 6. AGE (In years last birthday)
<i>61</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>PA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>MONTGOMERY</i> | | Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda Md.</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Yours Home 5721 Wisconsin Ave Dir of Comput Ctr.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Dir of Comput Ctr.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>MONTGOMERY</i> | | 13c. CITY OR TOWN
<i>BETHESDA</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>8207-Lilly St</i> | |
| 14. FATHER'S NAME First <i>CLINTON E</i> Middle <i>T</i> Last <i>TAWNEY</i> | | | 15. MOTHER'S MAIDEN NAME First <i>ALICE</i> Middle <i>BEAMER</i> Last <i>BEAMER</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>182 30 2978</i> | | 17. INFORMANT
<i>Hospital Records</i> | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Carcinoma of colon</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 1538 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>68</i> , to <i>Dec 2</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Dec 2</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Blaine H. Eig</i> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>BLAINE H. EIG</i> | | 22e. ADDRESS
<i>9501 Georgia Circle Bethesda Md</i> | | 22c. DATE SIGNED
<i>12/9/68</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>12-12-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>SALEM E.U.B. TWP</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>GETTYSBURG ADAMS PA</i> | | | |
| 24. FUNERAL DIRECTOR
<i>ROBERT A. Pumphrey</i> | | | | 25a. REC'D BY REGISTRAR
<i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |
| 7557-WISCONSIN AVE, BETHESDA, MD | | | | | | | | | |

10000

THE STATE OF TEXAS

State of Texas



Superior

General Agent

See 2nd page for details

W. J. R. 12/1/12
B. J. R. 12/1/12
H. E. R. 12/1/12

DEC 1 1912

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| 18010 | | | | | | | | | | 18021 | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Amy Middle Louise Last WITMAN | | | | | 2a. DATE OF DEATH
Dec Month 16 Day 1968 | | | | | 2b. HOUR
12:50A | | | | | | | | | |
| 3. SEX
Female | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
Dec 14, 1968 | | | 6. AGE (In years last birthday)
YRS. 12 | | | IF UNDER 1 YEAR
MONTHS 12 DAYS | | IF UNDER 24 HRS
HOURS 12 MIN | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia COUNTY Washington | | | 13c. CITY OR TOWN
Washington | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
#8 Neptune Green | | | | | | | | | | |
| 14. FATHER'S NAME First David Middle C. Last WITMAN | | | | | 15. MOTHER'S MAIDEN NAME First Judith Middle A. Last BURDENS | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT (Mother) #8 Neptune Green Washington, D. C. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 777x Prematurity
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | | | | | | | | | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from Dec 14, 1968 , to Dec 16, 1968 , that XX (we) lost the deceased alive on Dec 16, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) not view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Gene P. Swartz, M.D. | | | | | | | | | | 22c. DATE SIGNED
Dec 17, 1968 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Gene P. SWARTZ, M.D. | | | | | | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
Burial | | | | | 23b. DATE
12-18-68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | | | | | | | | |
| 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S NAME (Type)
B. A. PUMPHREY FUNERAL HOME | | | | | | | | | | 25a. REC'D BY REGISTRAR
DEC 26 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

2

(red)

15. *Chrysomelidae* - 6 (21.6%)

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DOI: 10.1002/for

TABLE 1. *Continued*

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|-----------------|--|--|--|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | First
GRACE G. | | Middle
WYNDHAM | | Last
WYNDHAM | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Dec. 4 19 68 530 | |
| 3. SEX
Female | 4. RACE
Cauc | 5. DATE OF BIRTH
31 March 1893 | | 6. AGE (In years)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Australia | | 7b. CITIZEN OF WHAT COUNTRY?
Australia | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | 2c. DATE PRONOUNCED DEAD
Month Day Year 19 | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DISTRICT OF COLUMBIA | | 13b. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4835 Yuma Street | | | |
| 14. FATHER'S NAME
First Middle Last
White | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Roberts | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Washington, D.C. ADDRESS
Mrs. Nereda Sommerville, 4835 Yuma St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Rupture Aortic Aneurysm.</u>
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cardio Vascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden.</u>
<u>4 years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | John G. Ball, M. D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED
Dec. 5, 1968 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
12/6/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland Md. | | | |
| 24. FUNERAL DIRECTOR
Taltavull Funeral Home
1748 Wisconsin Ave., N.W. Washington, D. C. | | | | 25a. REC'D BY REGISTRAR
DATE DEC 9 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-66

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|---|--|--|--|---|--|--|--|--------------------------------|--|--|--|
| 18012 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 18023 | | | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
MRS MARY R. YEATMAN | | | | | | 2a. DATE OF DEATH
Month Day Year
December 16, 1968 | | | | | | 2b. HOUR
4:30 P.M. | | | | | | | | | | | |
| 3. SEX
Female | | | | 4. RACE
White | | | | 5. DATE OF BIRTH
October 26, 1884 | | | | 6. AGE (In years last birthday)
84 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS
2 2 | | | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
District of Columbia | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery County Md. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Crescent Lane Nursing Home | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)
9000 WISCONSIN AVE., STADT
BETHESDA MARYLAND | | | | 13b. COUNTY
Montgomery | | | | 13c. CITY OR TOWN
Kensington | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
9605 Parkwood Drive | | | | | | | |
| 14. FATHER'S NAME
First Middle Last
John Cantwell | | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary Bigan | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | | 16b. SOCIAL SECURITY NO.
579-60-4950 | | | | 17. INFORMANT
Francis X. Yeatman | | | | Address
Bethesda, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Cardiovascular Collapse
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary Infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis
Approximate interval between onset and death: sev. hours
24 hours
Many years | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Relative Inactivity | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1963, to Dec 16, 1968, that (I) (we) last saw the deceased alive on Dec 16, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Leon H. Mitchell M.D. | | | | | | 22c. DATE SIGNED
Dec 16, 1968 | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
GEORGE H. MITCHELL | | | | | | 22e. ADDRESS
11125 Rockville Pike
Rockville, Maryland | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE
12-20-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | | | 23d. LOCATION (City or Town) (County) (State)
Suitland Prince George's Md | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey
7557 Wisconsin Ave., Bethesda, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE
DEC 26 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | |

68081

101

DEC 28 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18013

CERTIFICATE OF DEATH

18024

| | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(Type or print) LIONEL JUSTUS ZIERDT | | | 2a. DATE OF DEATH
12 Month 6 Day 68 Year | | | 2b. HOUR
9:30 AM | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
JUNE 12, 1900 | | 6. AGE (In years
lost birthday)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign
country) PENNA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. AMERICA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | |
| 10. CITY OR TOWN OF DEATH
KENSINGTON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
3001 JENNINGS ROAD | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
MECHANIC FOREMAN | | | 12b. KIND OF BUSINESS OR
INDUSTRY
TRUCKING | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
KENSINGTON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3001 JENNINGS ROAD | |
| 14. FATHER'S NAME
JUSTUS | | | 15. MOTHER'S MAIDEN NAME
AMANDA | | 15. MOTHER'S MAIDEN NAME First Middle Last
KLINGER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) YES | | | 16b. SOCIAL SECURITY NO.
578-12-7913 | | 17. INFORMANT
MARIE E. ZIEDT
Address
3001 JENNINGS ROAD
KENSINGTON, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG (PRESUMPTIVE)
1621 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. 163X
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CHRONIC OBSTRUCTIVE EMPHYSEMA, ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1966, to 12/6, 1968, that (I) (we) last
saw the deceased alive on 12/5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Richard H. Pollen MD | | | | | | 22c. DATE SIGNED
12-6-68 | | 22d. PHYSICIANS
NAME (Type) RICHARD H. POLLEN MD | | |
| 22e. ADDRESS
10400 CONNECTICUT AV, KENSINGTON, MD | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE
DEC 9, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
PARK LAWN CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
ROCKVILLE MONTGOMERY MD. | | |
| 24. FUNERAL DIRECTOR
W.W. CHAMBERS Co. | | | | | | 25a. REC'D BY REGISTRAR
DEC 11 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |



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